

Avonlea Dementia Care Limited

Current Status: 3 March 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Partial Provisional Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Avonlea Dementia Care currently provides dedicated dementia level care for up to 54 residents and hospital – geriatric medical level care for up to 10 residents. On the day of audit, there were 40 residents across four dementia homes and 10 residents in the hospital unit. The facility is divided into six separate units.

This partial provisional audit was completed to review the services readiness and appropriateness to provide specialist hospital (Psychogeriatric) services in one of the current dementia units. The 11-bed unit is currently closed off and being renovated in preparation for the change of care level. The resident rooms and communal areas including bathrooms were assessed as appropriate for providing psychogeriatric (PG) level care. It was also identified that the staffing/roster, equipment and organisational policies/procedures and processes are appropriate for also providing psychogeriatric level care and in meeting the needs of the residents at Avonlea.

The service is managed by an experienced aged care operations manager. She is supported by a clinical nurse manager, a stable staff and the management team at Dementia Care NZ.

The service has addressed the previous one shortfall from their certification audit around medication fridge temperatures.

There is an improvement required by the service around completing identified building renovations to the psychogeriatric unit.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Avonlea Dementia Care Limited
Certificate name:	Avonlea Dementia Care Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Partial Provisional Audit
Premises audited:	Avonlea Dementia Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); dementia care
Dates of audit:	Start date: 3 March 2014 End date: 3 March 2014
Proposed changes to current services (if any):	
To add specialist hospital services (psychogeriatric level care) . The service is currently renovating one of their 11 bed dementia units to become a specific psychogeriatric unit.	

Total beds occupied across all premises included in the audit on the first day of the audit:	52
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Audit Team

Lead Auditor	XXXXX	Hours on site	4	Hours off site	2
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	4	Total audit hours off site	3	Total audit hours	7
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Number of residents interviewed		Number of staff interviewed		Number of managers interviewed	4
Number of residents' records reviewed		Number of staff records reviewed	4	Total number of managers (headcount)	3
Number of medication records reviewed	8	Total number of staff (headcount)	59	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Monday, 10 March 2014

Executive Summary of Audit

General Overview

Avonlea Dementia Care currently provides dedicated dementia level care for up to 54 residents and hospital – geriatric medical level care for up to 10 residents. On the day of audit, there were 40 residents across four dementia homes and 10 residents in the hospital unit. The facility is divided into six separate units.

This partial provisional audit was completed to review the services readiness and appropriateness to provide specialist hospital (Psychogeriatric) services in one of the current dementia units. The 11-bed unit is currently closed off and being renovated in preparation for the change of care level. The resident rooms and communal areas including bathrooms were assessed as appropriate for providing psychogeriatric (PG) level care. It was also identified that the staffing/roster, equipment and organisational policies/procedures and processes are appropriate for also providing psychogeriatric level care and in meeting the needs of the residents at Avonlea.

The service is managed by an experienced aged care operations manager. She is supported by a clinical nurse manager, a stable staff and the management team at Dementia Care NZ.

The service has addressed the previous one shortfall from their certification audit around medication fridge temperatures.

There is an improvement required by the service around completing identified building renovations to the PG unit.

Outcome 1.1: Consumer Rights

Outcome 1.2: Organisational Management

Dementia Care NZ is the parent company for Avonlea Dementia Care and has a current charter and business plan and a quality and risk organisational plan that aligns with the business plan (July 13 - June 14). The vision and values statement sets out the philosophy of the providers. Avonlea Dementia Care holds regular meetings including (but not limited to); quality, infection control, staff, health and safety and resident/family meetings.

The operations manager of Avonlea reports to the proprietors on a range of issues on a monthly basis. The organisation provides training days with the clinical managers and senior management team to ensure at least eight hours annually of professional development activities occurs including those related to managing a hospital. Caregivers complete the required dementia standards.

The organisation provides PG level care in six of their facilities. There are relevant care and support policies including relevant clinical procedures for the management of hospital level residents.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice

including (but not limited to) clinical procedures, Non Violent Crisis Intervention. Competency packages are in place. The Staffing Levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The service has developed a draft roster for the introduction of psychogeriatric (PG) level care into Aroha unit. There is a RN rostered across all shifts within the unit.

Outcome 1.3: Continuum of Service Delivery

The medication management system includes, medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the current guidelines. There is a locked medication cupboard in the psychogeriatric (PG) unit. Controlled drugs are stored in a locked safe in a locked cupboard in hospital treatment room. A controlled drug register is maintained. The previous shortfall around the medication fridge temperatures identified in the certification audit has been addressed. The annual in-service training also includes specific training around medication management. Medicine management information is well established throughout Avonlea and the organisation. The service has a central kitchen off one of the dementia units. Food is provided to the kitchenettes in each units via insulated trolleys. Food will be served to residents in the PG unit from the kitchenette. The cooks have completed food safety certificates. Food safety is also completed by staff as part of the annual in-service programme. There is a dietitian contracted who reviews and advises on menus 12 monthly and more often if necessary.

Outcome 1.4: Safe and Appropriate Environment

The service has in place management of waste and hazardous Materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. There is a secure sluice off the planned PG unit that includes chemicals in locked cupboards. Protective equipment was sited in the sluice and laundry. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer that expires on the 1st July 2014. The planned psychogeriatric (PG) unit is in the process of being renovated. The PG unit has corridors that allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located around the hallways and in the bathrooms. Access to the outside is appropriate for mobility equipment. Outside area has seating and shade is provided. Pathways, seating and grounds are well maintained. The PG unit (11 resident rooms) has one mobility bathroom (shower/toilet), and two other toilets. The bathroom and one toilet are large enough for two staff and mobility equipment. Residents rooms are of sufficient space to allow care to be provided and for the safe use and manoeuvring of mobility aids and staff. There is a combined dining area and lounge area that can accommodate hospital level (PG) residents and mobility aids. The laundry is located off the hospital unit with dirty/clean entrance/exit and effective separation of dirty laundry. The service provides staff training to implement its policies and procedures for civil defence, equipment and other emergencies. Fire safety

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	The planned PG unit is in the process of being renovated, including resident rooms and bathrooms.	Complete all building renovations prior to occupancy	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C) S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA

Evidence:

Avonlea currently provides dedicated dementia rest home level care for up to 54 residents and hospital – geriatric medical level care for up to 10 residents. On the day of audit, there were 41 residents in the dementia homes (one 11-bed home is currently being renovated for PG level care). The facility is divided into six separate units. Awhii whanau includes eight resident beds, Hoa Pumau includes 15 resident beds, Aroha includes 11 resident beds and Mahal (hospital)10, Rudo and Ofa house 10 resident beds in each. There is one dedicated dementia respite bed.

The purpose of this partial provisional audit was to verify the appropriateness of Aroha unit to provide specialist hospital services – psychogeriatric (PG) level care across the units 11 beds. As part of the organisations business planning that have determined that adding PG services will assist with 'aging in place' and will continue to align with their vision: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'.

The vision and values statement sets out the philosophy of the providers. Avonlea holds regular meetings including (but not limited to); quality, infection control, staff, health and safety and resident/family meetings.

ARHSS D5.1: Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one's care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely units provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness.

Dementia Care NZ is the parent company for Avonlea and has a current charter and business plan and a quality and risk organisational plan that aligns with

the business plan (July 13- June 14). The operations manager and a quality and systems manager for the organisation manage the quality programme. There are documented objectives for the current financial year including (but not limited to): vision and values, quality plan, health and safety, infection control, resident occupancy, benchmarking, medication management, complaints process, human resources, restraint minimisation, continuous quality improvement, communication, education and training for staff including orientation and competencies, food safety, fire and evacuation and code of residents rights.

Dementia Care NZ Ltd has well established business, strategic, quality and risk organisational plans being implemented at Avonlea. The operations manager at Avonlea is responsible to the directors and reports on a monthly basis on a variety of issues relating to the strategic and quality plan. The service has a reconfiguration services plan for the introduction of PG level care.

ARHSS D17.5 (hospital), The operations manager is an experienced aged care manager and has been in the role for the last four years. She has completed a management course and has worked in various management roles within the organisation during the last 11 years. The clinical manager (has been in the role for the last three months) and currently provides clinical oversight to service. She has four years' experience in other PG units. The organisation provides training days with the clinical managers and senior management team to ensure at least eight hours annually of professional development activities occurs including those related to managing a hospital. The managers at Avonlea are supported by the management team of Dementia Care NZ.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA
Evidence: <p>During a temporary absence of the operations manager, the clinical nurse manager assumes the role. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p> <p>The organisation provides PG level care in six of their facilities. There are relevant care and support policies including relevant clinical procedures for the management of hospital level residents. At Avonlea there is currently a house GP, Physiotherapist and a dietitian (visits monthly). There is also an organisational Occupational Therapist. At an organisational level there is a Principal Clinical Services Manager that provides clinical support and leadership. Allied health professionals are accessed on an as required basis.</p>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA

Evidence:

Avonlea currently employs a total of 59 staff. Staff orientation policy and procedures includes training and support packages for operations manager, registered nurses, caregivers, activities team, cook, and kitchen staff. There are job descriptions available for all positions and staff have employment contracts.

Four staff files were reviewed (clinical nurse manager, registered nurse, two caregivers). Job descriptions were evident in all files reviewed. Performance appraisals are up to date.

The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates sighted for all registered nurses, and allied/medical staff.

There are comprehensive human resources manual, which includes policies around recruitment, selection, orientation and staff training and development. Four staff files were reviewed. Reference checks are completed before employment is offered and are evident in the four staff files reviewed.

ARHSS D 17.9: Orientation programme and packages for all roles. The orientation programme is relevant to dementia care, hospital and PG level care and includes a session how to implement activities and therapies. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice.

ARHSS D17.10 Competency packages for registered nurses include - 'best friends' approach to care, restraint minimisation and safe practice, first aid, ACE dementia series, delirium, syringe driver, medication, neurological conditions and leadership.

Caregivers competency package - 'best friends' approach to care, restraint minimisation and safe practice, first aid, taking vital signs, safe medication administration, ACE programme and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.

An education coordinator is employed to oversee the organisation's education programme for all homes and is available to facilitate sessions. The education coordinator develops the annual education plan in conjunction with the operations manager. There are essential/compulsory attendance sessions. Other topics are added to the plan as required following feedback from audits, complaints, incidents/accidents, infection, health and safety issues and quality improvement initiatives. The education coordinator manages a spreadsheet of all staff and records all completed orientations, competencies and education attended.

ARHSS D17.11: There are 48 caregivers employed in Avonlea that work across the dementia units. Twenty-nine have completed the required dementia standards, and seven caregivers are in the process of completing. There are 11 new staff that are yet to commence. Advised caregivers with dementia training will be rostered to work in the PG unit. The manager stated that they have sufficient caregivers currently to cover the PG roster. The organisation supports new graduates with competency packages. All RNs have commenced their PDRP and annual RN study days are held. Three sessions based around 'leadership tools' have been held with RNs.

ARHSS D17.7: A diversional therapist currently working in Admatha Lodge (PG) is transferring to take on the activities role at Avonlea within the PG unit. She has completed (but not limited to); the dementia standards, 'best friends' approach to care, Non-violent crisis intervention training.

There is an in-service calendar completed for 2013 and currently being implemented for 2014. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

The Staffing Levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are currently in place and show staff coverage across the dementia units and the hospital unit. There is an registered nurse (RN) on 24/7 in the hospital unit.

The service has developed a draft roster for the introduction of PG care into Aroha unit. Currently the service has eight registered nurses that work at Avonlea. The manager has determined that although they can currently cover all 24 hours, another two RN's will be employed. The service also accesses RNs from Admatha as required as well.

There is a clinical manager three days a week and two days she works as a RN in the hospital.

ARHSS D17.3, D17.8

PG unit (11 residents).

AM shift:

RN 06.45 - 1515

caregiver 0700 - 1500

caregiver 0700 - 1230

PM shift:

RN 1500 - 2315

caregiver 1500 - 2300

caregiver 1700 - 2100

DT 1300 - 1700

Nocte:

RN 2300 - 0700

caregiver 2300 -0700

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: FA
Evidence: ARHSS D19.2d: The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) specific medication devices (such as spacers, oxygen, IV therapy, sub-cut fluid administration, novo-pen, etc.) h) medication errors, i) emergency medications, j) staff training, k) storage and administration of controlled drugs, l) alternative medication and m) medication audit. The service uses two weekly robotic systems for regular medication and medico blister packs for PRN medications. The RN checks these on arrival from the supplying pharmacy.

ARHSS D15.3g: There is a locked cupboard in the new PG unit, which includes a new medication trolley. Stock medication and controlled drug safe is kept in the hospital treatment room. Medication reconciliation is implemented via the 'Medication Management on Admission and Transfer policy' RN's deemed competent will administer medications in the PG unit. Orientation to medications include a self-learning package and supervised medication rounds. Annual competency and medication education has been completed for staff across the facility that administer medication.

The hospital unit has emergency medications, suction and oxygen concentrator. Nurse Maude is accessed for advice, resources and syringe drivers as required. RNs have completed syringe driver competencies 2013. Medication training is provided annually (May 13) and CD administration Sept 2013.

The previous report identified a gap around the medication fridge temperature (0-1 degrees Celsius) recorded. This has been addressed by the service and the daily records sited confirmed this.

D16.5.e.i.2; Eight medication charts (hospital) reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. GP prescribing meets the legislative requirements. All medication charts had current photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts. There is no gaps in the administration signing sheets.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA
Evidence: <p>There is a kitchen service manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. The main kitchen provides food to all the kitchenettes in each unit. Food is to be transported by hot boxes to the PG unit and serviced from the open plan kitchenette. Temperature checks are undertaken daily for the fridges, freezers, sanitizer, and hot foods at each mealtime (sighted). Food in the pantry is stored off the floor and stock is rotated each week when the food order is delivered. Perishable food is covered and dated in the fridges. The cooks have undertaken food safety and hygiene training. Food safety competencies are also completed with all staff. The two cooks have completed food-handling certs. There is a four weekly menu in place. An organisational food services management consultant reviews and advises on menus 12 monthly and more often if necessary. The service also has access to a Dietitian monthly for review of resident needs. A resident dietary profile is undertaken on each resident on admission and a copy provided to the cook and updated as required by the RN's. These were sighted in a folder in the kitchen.</p>

Special diets (e.g. gluten-free), meal textures, likes and dislikes are known and catered for. Special equipment is available as required such as lipped plates. There is a fridge in the PG unit, advised that this will be stocked to ensure nutrition needs are met across the 24 hours. Nutrition and hydration is identified as a component of the care plan. Kitchen service audits undertaken March and Sept 13 have 100% compliance. Ecolab provide the chemicals and conduct quality control checks. Chemicals are stored safely. Common kitchen hazards are identified.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

The service has in place management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include, (but are not limited to): a) sharps procedure and b) cleaning/chemicals procedures and c) exposure

to blood or other body fluid contamination policy. Annual training is provided to the staff January 2013. There is a sluice on the other side of the PG unit that would be accessed and includes chemicals in locked cupboards. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Protective equipment was sited in the sluice and laundry.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: PA Low

Evidence:

The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer that expires on the 1st July 2014. The planned PG unit is in the process of being renovated. Shared ensembles between rooms have been removed to make for larger resident rooms.

The maintenance person checks the maintenance books in each nurse station for day-to-day requests. Hot water temperature is checked weekly at the nearest and furthest point from the heating source. There is a pool of contractors available for larger maintenance problems. Planned maintenance schedules are in place for internal and external building maintenance. All resident related equipment has been checked. Electrical testing of equipment is current. Contractors complete a work sheet and report that is forwarded to the operations manager. An environmental safety audit is completed six monthly.

ARHSS D.4.1c: The small PG unit provides a homelike and safe environment.

ARHSS D15.2a: Relatives are encouraged to bring in some of the residents personal furniture possessions if able.

ARHSS D15.3a,b,c The PG unit has corridors that allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located around the hallways and in the bathrooms. Access to the outside is appropriate for mobility equipment. There is a secure outdoor garden area with walkways. Outside area has seating and shade is provided. Pathways, seating and grounds are well maintained. The current outdoor garden area is separate from the other areas.

ARHSS D15.3e,f,g: The following equipment has been ordered (but not limited to); hospital beds, suction, hoist-sling, oxygen concentrator, pressure area equipment, lazy-buy chairs on wheels, bedrail covers, topper pads, lifting belts.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low
Evidence: The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer that expires on the 1st July 2014. The planned PG unit is in the process of being renovated. Shared ensuites between rooms have been removed to make for larger resident rooms.
Finding: The planned PG unit is in the process of being renovated, including resident rooms and bathrooms.
Corrective Action: Complete all building renovations prior to occupancy
Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: The PG unit (11 resident rooms) has one mobility bathroom (shower/toilet) another mobility toilet and one smaller toilet room. The bathroom is large enough for two staff and mobility equipment. The bathrooms are still in the process of being renovated (link 1.4.2.1)

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA
Evidence: Residents rooms are of sufficient space to allow care to be provided and for the safe use and manoeuvring of mobility aids and staff. Doors into resident rooms are wide enough to allow the movement of lazy boy chairs.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: There is a combined dining area and lounge area in the PG unit that can accommodate hospital residents and mobility aids. There is also another small sitting area.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

The service has in place policies and procedures for effective management of cleaning and linen practices. The laundry is located off the hospital unit with dirty/clean entrance/exit and effective separation of dirty laundry. Soiled laundry is sorted into different coloured bags or buckets to identify type of treatment required. Storage of Soiled Linen policy includes transportation of linen around the facility. Laundry and cleaning audits are completed on a regular basis (cleaning Sept 2013 – 100% and Laundry Jan 2014 – 95%). The service has a secure area for storage of cleaning chemicals in the locked laundry. Chemicals are labelled. Material Safety data sheets are available and displayed in the chemical storage area. There is a locked sluice available off the PG unit.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA
Evidence: <p>The service provides staff training to implement its policies and procedures for civil defence, equipment and other emergencies. Fire safety and evacuation training is provided to staff during their orientation phase and annually (last Feb 2014). Staff also complete competencies. The following training was provided in 2013; fire warden training, fire drills, and first aid. There is an approved evacuation scheme, there is no changes required to the current evacuation plan and secure doors remain the same.</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence kit and water supply is in place and meets requirements. There is someone on duty 24/7 with a current first aid certificate.</p> <p>Resident rooms, toilets/showers and the lounge/dining areas have call bells. Senior Staff in each unit also carry phones to ring internally for support in an emergency.</p> <p>The service policies and procedures require that contractors are appropriately identified and a Contactor's folder is well established. Security policy is in place and a daily security check is documented.</p>

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: General living areas and resident rooms are appropriately heated and ventilated. There are scope heaters in the resident rooms and heat pump in lounge/dining room. Residents have access to natural light in their rooms via at least one external window and there is adequate external light in communal area.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme is reviewed annually, this was completed with ICNs across the organisations. The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level. There is an established and implemented infection control programme that is linked into the objectives of the quality and risk management plan for 2013-2014. The quality committee includes a cross section of staff from all areas of the service. The IC meeting at Avonlea meets monthly and at an organisational level six monthly. The facility has access to professional advice within the organisation, from GP's and from an IC consultant. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines, there has been no identified outbreaks since previous audit.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>