

# KVTN Investments Limited

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Current Status: 17 February 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance 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

The facility is operated KVTN Investments Limited trading as Alexandra Rest Home. Alexandra Rest Home provides residential care for up to 45 residents who require rest home level care. There are 41 residents in Alexandra Rest Home on the day of this audit. Residents and family interviewed provided positive feedback on the care provided.

There are seven areas identified as requiring improvement during this audit relating to the development of corrective action plans to address areas identified as requiring improvement; management of some aspects of food service delivery; the currency of documented medication standing orders; management of resident files including completion of an initial care plan, risk assessments and short term care plans to address short term issues.

## Audit Summary as at 17 February 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 17 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 17 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 17 February 2014

Includes 13 standards that support an outcome where 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 17 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure 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.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 17 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 17 February 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## 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

<b>Legal entity name:</b>	KVTN Investments Limited		
<b>Certificate name:</b>	KVTN Investments Limited		
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Alexandra Rest Home		
<b>Services audited:</b>	Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 17 February 2014	<b>End date:</b> 17 February 2014	
<b>Proposed changes to current services (if any):</b>			

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	41
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## Audit Team

<b>Lead Auditor</b>	XXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	16	Total audit hours off site	12	Total audit hours	28
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Number of residents interviewed	5	Number of staff interviewed	7	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	25	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

## Declaration

I, XXXX , Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) 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	Yes
g)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Tuesday, 25 February 2014

## Executive Summary of Audit

### General Overview

Alexandra Rest Home provides residential care for up to 45 residents who require rest home level care. There are 41 residents in Alexandra Rest Home on the day of this audit. The facility is operated KVTN Investments Limited trading as Alexandra Rest Home. Residents and family interviewed provided positive feedback on the care provided.

There are seven areas identified as requiring improvement during this audit relating to the development of corrective action plans to address areas identified as requiring improvement; management of some aspects of food service delivery; the currency of documented medication standing orders; management of resident files including completion of an initial care plan, risk assessments and short term care plans to address short term issues.

### Outcome 1.1: Consumer Rights

The service provides an environment conducive to effective communication. Residents and family members interviewed report that services are provided in a manner that respects residents' rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.

The facility manager is responsible for complaints and a complaints register is maintained. The residents and their family members can use the complaints issues forms or raise issues at the residents' monthly meetings.

### Outcome 1.2: Organisational Management

KVTN Investments Limited trading as Alexandra Rest Home is the governing body and is responsible for the service provided at Alexandra Rest Home. Planning documents reviewed include a philosophy of care and goals and objectives for the service.

Systems are in place for monitoring the service provided at Alexandra Rest Home, including regular reporting via monthly quality meetings that are attended by the directors/owners/manger. The facility is managed by the directors/owners. They are supported by a care manager who is a registered nurse with aged care experience and who is responsible for oversight of clinical care. Registered nurse cover is provided seven days a week between 8.30am and 5pm.

There is one area identified as requiring improvement relating to the development and monitoring of corrective action plans to address any

deficits that have been identified following adverse events and during internal audits. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery and that this information is reported to the managers/owners and staff. There is an internal audit programme in place. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), pharmacists, dietitian, and general practitioners (GPs) is occurring.

In-service education is provided for staff via six hour study days as well as at least once a month via the in-service education programme. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care. Review of staff records provides evidence of human resources processes being followed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of two caregivers. The care manager and facility manager are on call after hours. All care staff interviewed report there is adequate staff available.

### **Outcome 1.3: Continuum of Service Delivery**

Systems are implemented that evidence service delivery is provided with resident and/or family input and coordinated to promote continuity of care. Residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs. A sampling of residents' clinical files validates evaluations of care plans are within stated timeframes. There are areas requiring improvement around initial assessments and care plans to be completed by a registered nurse, risk assessments to be completed within required timeframes and recording of interventions to meet residents' needs.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Activities are provided either within group settings or on a one-on-one basis.

An appropriate medicine management system is implemented. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies. There are no residents who self-administer medicines at the facility on audit day. There is an area requiring improvement around the currency of standing orders.

Alexandra rest home has a kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. Residents' individual dietary needs are identified, recorded and communicated to kitchen staff. There are areas requiring improvement around current



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	(i) A registered nurse has been involved in three medication errors and a corrective action plan has not been developed and implemented to assess their competency to be involved in medicine management. (ii) Internal audits are reviewed with areas requiring improvement identified but there is no documented evidence available indicating that corrective action plans have been developed and	(i) Provide documented evidence that a corrective action plan has been developed, implemented and monitored to address the competency of the registered nurse who has made three medication errors in a seven month period; (ii) provide documented evidence that corrective action plans are developed and implemented to address areas	90

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
				implemented to address these required improvements.	identified as requiring improvement.	
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.3.1	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	PA Moderate	One initial care plan sighted was completed by the manager and signed by the registered nurse 20 days later.	Provide evidence the initial assessments and care plans are completed by a registered nurse on admission to the facility.	90
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Risk assessments are not always conducted within specified timeframes.	Provide evidence risk assessments are completed within timeframes required.	90

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Interventions are not consistently recorded to meet residents' needs. Two residents with wounds do not have wound care assessments, wound treatment plans and wound evaluations recorded. Full neurological observations were not recorded for two residents who sustained injuries to their heads following a fall. A resident who is exhibiting challenging behaviours does not have a record of this challenging behaviour on their care plan; and short term care plans are not recorded for	Provide evidence resident's interventions to meet resident's needs are recorded.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				short term problems this resident has.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Medication standing orders are not current.	Provide evidence standing orders are current and authorised by GPs.	180
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Menu review was last conducted in 2011. There is evidence of 2008-2009 summer menus being followed by kitchen staff on audit day.	Provide evidence of current menu and adherence by staff to the menu.	180
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	There is no evidence the decanted foods are dated.	Provide evidence decanted foods are dated.	180

## Continuous Improvement (CI) Report

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>

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

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## Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

### Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

Open disclosure procedures are in place to ensure staff maintains open, transparent communication with residents and their families. Residents' files reviewed (five rest home) provides evidence that communication with family is being documented in residents' progress notes. At admission the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about, as well as what time of day they wish to be notified for any discussion. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.

Residents (five rest home) and family (two rest home) interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The director/manager advises access to interpreter services is available if required via members of staff, the residents family and interpreter services. The director/manager advises they currently have one resident with limited English and their family has provided translation charts of key phrases that are on the wall in the resident's bedroom.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

The ARC requirements are met.

**Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

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

**Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

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

### **Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

An electronic complaints register is maintained and a printout of this register is reviewed during this audit. The register includes the nature of the complaint, dates and actions taken. There are four complaints recorded for 2013 and none for 2014.

Reporting of complaints occurs via monthly meetings. The director/manager advises there have been no complaint investigations by the Health and Disability Commissioner, the District Health Board, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents (five) and family (two) interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held monthly and review of these minutes provides evidence of residents' ability to raise any issues they have. This was confirmed during interviews with residents.

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality and staff meeting minutes provides evidence of reporting on complaints.

The ARC requirements are met.

#### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

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

**Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

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

## 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  KVTN Investments Limited is the governing body and is responsible for the service provided at Alexandra Rest Home. A business plan (August 2013) is reviewed

and includes a purpose, scope, direction and goals and objectives. Also reviewed are documented values, mission statement and a philosophy of care. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Meeting schedules and minutes reviewed show that monthly quality, staff, and resident meetings are held. Meeting minutes are available for review by staff along with graphs of various clinical indicators.

The facility is managed by the two directors. One of the directors works Monday to Friday 7.30am to 5.30pm and the other director/manager Monday to Thursday 9am to 2.30pm. An organisational chart is reviewed and the responsibilities for each of the directors/managers are identified along with reporting lines for staff. The personal file, training records and job description is reviewed for one of the managers/directors who works full time on site and provides evidence of appropriate ongoing education

The managers/directors are supported by a care manager / registered nurse (RN) who works Wednesday to Sunday inclusive from 8.30am to 5pm. There is another recently graduated (2012) registered nurse employed who works Monday and Tuesday between 8.30am and 5pm. The care manager has been in this role since September 2006 and has worked in the aged care sector as an RN since 2001. Both RNs have current annual practising certificates which are reviewed during this audit. The care managers personal file is reviewed and evidence of ongoing education is able to be reviewed during this audit.

Alexandra Rest Home is certified to provide rest home level care and there are 45 beds provided, 41 of which are occupied on the day of this audit. KVTN Investments Limited – trading as Alexandra Rest Home have contracts with the DHB to provide aged related residential care (rest home); long term support – chronic health conditions and aged respite care.

The ARC requirements are met

### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

### **Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** PA Low

**Evidence:**

The business plan (August 2013), risk management plan, quality management policy and philosophy and audit programme flowchart are used to guide the quality programme and includes quality goals and objectives.

There is an internal audit programme in place and completed internal audits for 2013 are reviewed. Review of quality improvement data provides evidence the data is being collated and analysed and reported to the monthly quality meetings as well as to staff via the staff meetings. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings and graphs are reviewed on the noticeboard in the staff room. Monthly resident meetings are held and are facilitated by an independent advocate who also provides pastoral care for residents.

Improvements are required with completion of corrective action plans as corrective action plans are not being consistently developed, implemented and monitored to address all areas requiring improvement (see criterion 1.2.3.8).

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service, reflects current accepted good practice, and references legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The two owners/directors/managers and the care manager are responsible for reviewing policies and procedures in consultation with staff. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff (three caregivers). Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.

A Health and Safety Manual is available that includes relevant policies and procedures. There is a hazard reporting system available as well as a hazard register. Chemical safety data sheets are available that identify potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed and all biomedical equipment has appropriate performance verified stickers in place.

Not all of the ARC requirements are met.

#### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

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

**Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

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

**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

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

**Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

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

**Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

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

**Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

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

**Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

<b>Attainment and Risk:</b> PA Moderate
<p><b>Evidence:</b></p> <p>An 'Audit Findings Report' is attached to the front of each internal audit completed and describes the summary of audit results, corrective actions/improvements/follow-up, identifies who is responsible for implementing the corrective action and follow-up, the date this is to be completed by, a signature when completed, and the date this was discussed at the quality meeting.</p> <p>'Monthly Findings Report' is used to record audits completed including any findings and improvements required. This report also includes; a summary of the numbers and types of various accidents and incidents; trends/areas for improvement; initiatives/successes; and numbers and types of infections.</p> <p>Three 'Incident Form for Medication Errors' forms dated 27 May 2013, 20 August 2012 (although the manager advises this date is incorrect and must be 20 August 2013) and 09 December 2013 involving errors made by the RN are reviewed and none of them included the requirement for reassessment of competency to be involved in medicine management.</p>
<p><b>Finding:</b></p> <p>(i)The registered nurse has been involved in three medication errors and a corrective action plan has not been developed and implemented to assess their competency to be involved in medicine management. (ii) Internal audits are reviewed with areas requiring improvement identified but there is no documented evidence available indicating that corrective action plans have been developed and implemented to address these required improvements.</p>

**Corrective Action:**

(i) Provide documented evidence that a corrective action plan has been developed, implemented and monitored to address the competency of the registered nurse who has made three medication errors in a seven month period; (ii) provide documented evidence that corrective action plans are developed and implemented to address areas identified as requiring improvement.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**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 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

**Attainment and Risk:** FA

**Evidence:**

The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are reviewed and filed in residents' files. An 'Incident Form for Medication Errors' is used to record medication errors and any corrective actions required (see link 1.2.3.8).

A month by month register of adverse events is maintained and is collated at the end of each month to compile the monthly report that is submitted to the monthly quality and staff meetings.

There is an open disclosure policy. Resident files reviewed (five rest home) provide evidence of communication with families following adverse events involving the resident, or any change in the resident's condition.

Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and Procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).

The ARC requirements are met.

### Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

**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 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

**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 1.2.7: 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:**

Written policies and procedures in relation to human resources management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (five of five) along with reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and appropriate competency assessments (see link criterion 1.2.3.8), and annual practising certificates for the three registered nurses.

The manager/director and care manager are responsible for management of the in-service education programme and there is evidence available indicating in-service education is provided for staff via six hour study days that are provided three times a year at another facility. Staff are rostered to attend at least one of these study days each year. This education is supplemented with monthly in-service education sessions that are provided on site.

Individual records of education for each staff member are reviewed along with competency assessment and education spread sheets as well as education records for each session and in-service education programmes. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards through ACE. An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed. Current annual practising certificates are reviewed in a register for staff that require them to practice i.e. registered nurses (RN), pharmacists, dietitian, and general practitioners (GPs).

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The manager advises that staff are orientated for at least two shifts at the beginning of their orientation. The entire orientation process, including completion of competencies (as appropriate), takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided (i.e., the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy).

Care staff interviewed (three caregivers and one RN) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The ARC requirements are met.

#### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There is a clearly documented rationale (Service Provision Policy) for determining service provider levels and skill mixes in order to provide safe service delivery in place at Alexandra Rest Home.</p> <p>The minimum staff on duty is two care givers between 11pm and 7am. The care manager and facility manager are on call after hours: the care manager for clinical issues and the manager for non-clinical issues. Registered nurse (RN) cover is provided seven days a week between 8.30am and 5pm by the care manager on Wednesday to Sunday inclusive and the recently graduated registered nurse on Mondays and Tuesdays.</p> <p>The management team consists of the managers/owners/directors and the care manager/RN who is responsible for oversight of clinical care provided.</p> <p>Caregivers interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is enough staff on duty to provide them with adequate care.</p> <p>The ARC requirements are met.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Resident files sampled evidence that service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Four of four clinical staff (one registered nurse (RN) and three care staff) and one care manager / RN interviews confirm residents and/or family members are

involved in all stages of service provision.

Five of five residents and two of two family interviews confirm their input into service delivery planning and care evaluations

Five of five residents' files sampled demonstrate the long term care plans are developed by the RN, signed off by the resident and/or family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations.

Family communication sheets are maintained, sighted in all residents' files reviewed.

Documented handovers between shifts were sighted and the auditor evidenced verbal briefing/handover from am to pm shift.

GP interview was conducted and confirms that RN and the care manager inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

There are areas requiring improvement around initial assessments and care plans to be completed by a registered nurse and risk assessments to be completed within timeframes required.

Not all ARC requirements are met.

Tracer Methodology.

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

**Attainment and Risk:** PA Moderate

**Evidence:**

An initial care plan of a resident admitted in June 2013 was sighted to be completed and signed by the manager, who is not a registered nurse. This care plan was reviewed and signed by the registered nurse 20 days later.

**Finding:**

One initial care plan sighted was completed by the manager and signed by the registered nurse 20 days later.

**Corrective Action:**

Provide evidence the initial assessments and care plans are completed by a registered nurse on admission to the facility.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Five residents' files were sampled. There is evidence pain assessment has been conducted in one of five files sampled. Risk assessments such as falls, pressure area and continence have been conducted within specified timeframes in two of five files sampled. One resident's file reviewed of a resident with challenging behaviours and evidences challenging behaviour assessment was not conducted.
<b>Finding:</b> Risk assessments are not always conducted within specified timeframes.
<b>Corrective Action:</b> Provide evidence risk assessments are completed within timeframes required.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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

### **Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** PA Moderate

**Evidence:**

Documentation and observations made of the provision of services and/or interventions demonstrates that consultation and liaison is occurring with other services.

Five of five residents' files are sampled. Two of five residents' files provide evidence that the care plans record appropriate interventions based on the assessed needs and desired outcomes or goals of the residents; and the required encouragement, direction, or supervision of a resident who is completing an intervention for themselves is recorded in the care plans of two of the five care plans sampled. There is an area requiring improvement around recording of interventions to meet resident's needs (refer to criterion 1.3.6.1).

GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies are available in accordance with the requirements of the Service Agreement (ARC).

Five of five residents and two of two family members interviewed confirm the current care and treatments they are receiving meet their and their family member's needs. Family communication sheets record communications with family and are sighted in all of the residents' files sampled.

Not all ARC requirements are met.

### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

**Attainment and Risk:** PA Moderate

**Evidence:**

i) Review of two residents' files evidences adverse events occurring. Both residents' incidents/ accident forms are completed and following both adverse events family members have been notified of the event. Both residents had falls resulting in injury. One resident sustained a wound to their head as a result of the fall in their room. The second resident sustained a wound to their head and hand after a fall on the footpath outside the facility. There is no recorded evidence for both of the residents to indicate that wound assessments, wound treatment plans and wound evaluations have been undertaken; and full neurological observations were not undertaken and recorded following falls that resulted in injury to the resident's head. Observations are recorded in the progress notes for the resident who fell in their room including monitoring form where half hourly monitoring occurred.

Interview with the GP confirms the GPs awareness of the adverse events and the GPs examination of the residents post event.

ii) One resident's file reviewed of a resident who is exhibiting challenging behaviours and provides evidence the care plan records that there are no

challenging behaviour issues; and short term care plans are not recorded for short term problems, such as cellulitis and chest infection.

**Finding:**

Interventions are not consistently recorded to meet residents' needs. Two residents with wounds do not have wound care assessments, wound treatment plans and wound evaluations recorded. Full neurological observations were not recorded for two residents who sustained injuries to their heads following a fall. A resident who is exhibiting challenging behaviours does not have a record of this challenging behaviour on their care plan; and short term care plans are not recorded for short term problems this resident has.

**Corrective Action:**

Provide evidence resident's interventions to meet resident's needs are recorded.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)**

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

Residents (five of five) and family (two of two) confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There is a weekly activities programme displayed and daily activities are recorded on a white board.

Residents' files sampled demonstrate activities assessments and activities care plans are recorded. Interview with the activities co-ordinator confirms the activities programme meets the needs of the service group and the service has appropriate equipment.

Resident meetings are conducted by facility advocate (chaplain). Sighted October 2013 and January 2014 residents' meeting minutes. The ARC requirements are met.

**Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

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

**Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> All five residents' files sampled evidence that evaluations of care plans are within stated timeframes, however there is evidence in one of five files sampled of short term care plans not being recorded when the resident's condition changed (refer to criterion 1.3.6.1). Family are notified of any changes in resident's condition, evidenced in all five residents' files sample and confirmed in two of two family interviews. Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Residents' files evidence referral letters from specialists and other health professional, where required. The ARC requirements are met.

**Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

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

**Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

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

### 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:** PA Low

**Evidence:**

Visual inspection of the medication area in the facility evidences a secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drugs storage is secure. The controlled drug register is maintained, with weekly checks and physical stock takes of controlled drugs conducted.

Residents' medicines charts list all medications a resident is taking and there is evidence staff are signing off, as the dose is administered. Lunch time medication round was observed.

All staff authorised to administer medicines have current competencies (refer to criterion 1.2.3.8). Medication management training was last conducted in April 2013, confirmed by care manager and care staff interviewed.

Ten medicine charts were sampled and all charts demonstrate residents' photo identification, medicine charts are legible, medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

There are no residents at the facility who self-administer medicines.

There is an area requiring improvement around currency of standing orders.

Not all ARC requirements are met.

#### 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:** PA Low

**Evidence:**

Standing orders sighted provide evidence the GP signatures are dated 2011. The facility policy states the standing orders are to be reviewed annually.

**Finding:**

Medication standing orders are not current.

**Corrective Action:**

Provide evidence standing orders are current and authorised by GPs.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>The kitchen is inspected by the council and there is a certificate of hygiene displayed that expires 30th June 2014. Staff have conducted food safety training. Interview was conducted with the cook and evidences the cook is aware of residents' dietary requirements. Resident's individual dietary needs are documented and communicated to kitchen staff and kitchen staff are also informed if resident's dietary requirements change, confirmed at interview with the cook. Copies of dietary profiles are kept in the kitchen and in residents' files. Residents are offered fluids throughout the day. Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Residents (five of five) report their individual preferences are catered and adequate food and fluids are provided. Food temperatures, fridge and freezer temperatures are recorded, confirmed at cook interview and records sighted. There are areas requiring improvement that relate to current menu to be followed and decanted foods to be dated. Not all ARC requirements are met.</p>

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The service provides five weekly seasonal menus. The menu the cook was following on audit day was dated Summer menu, 2008 – 2009. The menu was last reviewed by a dietitian in 2011.
<b>Finding:</b> Menu review was last conducted in 2011. There is evidence of 2008-2009 summer menus being followed by kitchen staff on audit day.
<b>Corrective Action:</b> Provide evidence of current menu and adherence by staff to the menu.
<b>Timeframe (days):</b> 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Visual inspection of the kitchen evidences decanted food is not dated. This was confirmed at interview with the cook.
<b>Finding:</b> There is no evidence the decanted foods are dated.
<b>Corrective Action:</b> Provide evidence decanted foods are dated.
<b>Timeframe (days):</b> 180 (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 1.4.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The director/manager advises there have not been any alterations to the building since the last audit. A Building Warrant of Fitness is displayed at the main entrance that expires on 25 June 2014.

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

All buildings, plant, and equipment comply with legislation.

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

## NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

**Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are no residents utilising restraint or enablers at the facility on audit day. Documented systems are in place to ensure the use of restraint is actively minimized. Staff interviews and staff records evidence guidance has been given on restraint, enabler usage and prevention and/or de-escalation techniques. The service has an overarching risk and quality management system that

demonstrates compliance with the Standard.

Last certification audit identified criterion 2.1.1.2 as continuous improvement for preventing restraint use, this criterion is attained as fully attained at this surveillance audit. One resident's file reviewed of a resident with challenging behaviours and evidences challenging behaviour assessment was not conducted and care plan records there are no challenging behaviour issues (refer to criterion 1.3.3.3 and 1.3.6.1).

**Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

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### Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The infection control programme / policy details surveillance processes relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection log is maintained and infections are collated and reported to staff and management. Monthly infection summaries / graphs were sighted and there is evidence of these displayed in the staff room. Care staff interviewed report they are aware of any infections of individual residents by way of feedback from the registered nurse and the care manager, and in handovers.

#### Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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