

Warkworth Hospital Limited

Current Status: 20 November 2012

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

Warkworth Hospital provides residential care for up to 36 residents who require hospital or rest home level care. Occupancy on the day of the audit was at 34. No changes to the facility or management have occurred since the last audit.

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract and includes review of five aspects of service provision identified in the previous audit as requiring improvement. The service provider has effectively addressed all of these issues.

Ten areas requiring improvement have been identified during this audit. Three moderate risk issues relate to hot water monitoring, the medication management system and hazard management. Low risk issues relate to complaints records, clinical risk management plan, individual staff training records, records of reference checks, minutes of staff and management meetings, annual fire safety training and training in relation to use of enablers.

Audit Summary as at 20 November 2012

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
	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

Indicator	Description	Definition
	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 20 November 2012

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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 20 November 2012

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 medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 20 November 2012

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 20 November 2012

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.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 20 November 2012

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Infection Prevention and Control as at 20 November 2012

<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 3.91)

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:	Warkworth Hospital Ltd.		
Certificate name:	Warkworth Hospital		
Designated Auditing Agency:	Health Audit NZ Ltd.		
Types of audit:	Unannounced Surveillance		
Premises audited:	31 Blue Gum Drive, Warkworth		
Services audited:	Geriatric hospital and rest home care		
Dates of audit:	Start date: 20 November 2012	End date: 20 November 2013	
Proposed changes to current services (if any):			
	None		
Total beds occupied across all premises included in the audit on the first day of the audit:			34

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
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	16	Total audit hours off site	9	Total audit hours	25
Number of residents interviewed	3	Number of staff interviewed	5	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	8	Total number of staff (headcount)	44	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Monday, 9 December 2013

Executive Summary of Audit

General Overview

Warkworth Hospital provides residential care for up to 36 residents who require hospital or rest home level care. Occupancy on the day of the audit was at 34. No changes to the facility or management have occurred since the last audit.

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract and includes review of five aspects of service provision identified in the previous audit as requiring improvement. The service provider has effectively addressed all of these issues. Ten areas requiring improvement have been identified during this audit. Three moderate risk issues relate to hot water monitoring, the medication management system and hazard management. Low risk issues relate to complaints records, clinical risk management plan, individual staff training records, records of reference checks, minutes of staff and management meetings, annual fire safety training and training in relation to use of enablers.

Outcome 1.1: Consumer Rights

Communication processes are effective and satisfactory to residents and family. Interpretation services are available if required. The previous improvement required relating to signing of Resident Agreements on day of admission has been effectively addressed. The complaints process is made known to residents and families on admission and displayed in the facility. The complaints register is maintained up to date. Improvement is required to ensure that complaints records include follow up and recording of the complainant's response to the outcome of the investigation.

Outcome 1.2: Organisational Management

Quality and risk management systems are appropriate for the services provided. Quality and risk management requirements are included in staff orientation and staff meetings. The documented quality plan and goals are reviewed annually. Quality data is collected and reviewed monthly by the manager and staff and reported to the Directors. Improvement is required to ensure that records of meetings, discussions and decisions are maintained.

Documented service delivery policies, procedures and guidelines are up to date and available to staff in the work areas. There is a process in place to identify and control documents to ensure obsolete documents are removed from the system. There are safe processes for recording adverse events including taking appropriate actions to prevent recurrence. Incidence and trends are monitored and addressed as required.

There is a risk management plan in place but improvements are required to ensure that all potential clinical risks are identified and controlled, and the hazard management system is maintained up to date.

There is a suitable employment process in place but improvement is required to ensure that records of telephone references are maintained in staff files. A documented staff orientation program is implemented for all new staff. Relevant ongoing training is provided monthly for all staff. Improvement is required to ensure that individual staff training records are maintained up to date.

The facility is managed by a registered nurse with a current practicing certificate and relevant experience in age care. Twenty four hour registered nurse cover is provided with back up from the manager as required. The manager communicates with the directors at least monthly and staff meetings are held monthly but improvement is required to ensure that minutes of meetings and decisions are maintained.

Outcome 1.3: Continuum of Service Delivery

Care and support is provided by a range of health professionals. Clear time frames for service provision are defined and monitored. Residents confirm they are involved in the care planning process. Care plans and interventions are sufficiently detailed to provide appropriate care and support. Assessments and care plans are current and updated as required. The previous area of improvement regarding the currency of care plans had been adequately addressed

Activities are planned to meet the needs of the resident and although the provider has been without an activity coordinator for three weeks, the activity programme has been maintained. A new coordinator is scheduled to start within the next week. Individual activity goals are documented and ensure the provision of relevant and appropriate activities for each resident. Previous interests, hobbies, culture and ability is considered. Sufficient activities and outings are provided.

Warkworth Hospital provides an appropriate medication management system. The required policies and procedures are documented and available to staff. All medications are stored securely. Medications are monitored by the registered nurses and the GP. Administration is conducted by staff that have completed a medication competency. Improvement is required to three moderate risk areas. The provider is required to update the standing orders process to meet the current guidelines, ensure the medication fridge remains within the required temperature range and consistently follow the correct process for receiving verbal orders.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements.

Outcome 1.4: Safe and Appropriate Environment

The building has a current Building Warrant of Fitness. Both internal and external environments are safe for aged residents. There is an effective maintenance programme. Fire safety and electrical safety systems are in place. Improvement is required to ensure that all staff attend a fire training and trial evacuation at least once a year. There are appropriate and sufficient equipment and supplies. Functional tests and calibration of medical equipment are carried out annually. Improvement is required to ensure that monthly hot water temperature checks are maintained.

Outcome 2: Restraint Minimisation and Safe Practice

There are adequately documented guidelines on the use of restraints, enablers and challenging behaviours. There are no restraints in use. There are two residents voluntarily using an enabler to help them get in and out of bed. The previously identified area of improvement regarding the provision of de-escalation training has been sufficiently addressed, however there was some confusion amongst staff regarding the difference between a restraint and an enabler and the provision of related training could not be confirmed. Improvement is required to ensure that staff receive training about the use of enablers.

Outcome 3: Infection Prevention and Control

The infection control programme is clearly documented and is suitable for a hospital/rest home setting. The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored. There have been no infection issues or outbreaks since the last audit.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	10	0	5	2	0	0
Criteria	0	32	0	7	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	Complaints records are not always completed with regards to follow up or to the complainant's response to the investigation.	Ensure that complaints records are always completed with regards to follow up and include the complainant's response to the investigation.	180
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 Moderate			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Minutes of reviews of quality issues discussed at senior management meetings and at staff meetings are not maintained to provide a	Ensure that minutes of reviews of quality issues discussed at senior management meetings and at staff meetings are maintained to provide a	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				record verifying what has been reviewed, discussed or decided.	record verifying what has been reviewed, discussed and decided.	
HDS(C)S.2008	Criterion 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.	PA Moderate	The documented hazard management system is generic and has not been adapted to the situation at the facility. Hazard checks have not been implemented. The documented risk management plan does not address clinical risks relating to staffing and staff competence, contractual compliance, clinical care or resident safety, for example the risk to residents from the behavior of other residents.	Extend the risk management plan to include all areas of clinical risk that are relevant to the services provided. Identify and document the hazards and controls that are relevant to the service, and audit the effectiveness of the controls at least annually.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Records of telephone reference checks are not maintained in staff files.	Ensure that records of telephone reference checks are maintained in staff files.	180
HDS(C)S.2008	Criterion 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.	PA Low	Individual staff training records are not kept up to date in staff files.	Maintain individual staff training records up to date.	90
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		providers.				
HDS(C)S.2008	Criterion 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.	PA Low	Records of management and staff meetings are not maintained and documented in a format that enables verification of the information provided and discussed and any feedback received.	Ensure that records of staff meetings are consistently maintained and documented in a format that enables verification of the information provided and discussed and any feedback received.	90
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 Moderate			
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 Moderate	The current standing orders do not fully comply with the 2012 Standing Orders Guidelines. The number of dose(s) which can be given has not been documented for the use of Paracetamol, morphine, nitro lingual spray, loratadine or metoclopramide. The medication fridge is outside the temperature range required in order to maintain the efficacy of the medication. Evidence of weekly controlled drug checks have not been consistently maintained. Evidence of two persons confirming a verbal order has not been maintained in one out of two verbal	Amend the current standing orders to include the number of dose(s) for which the standing order is valid. Maintain the medication fridge at the required temperature. Maintain the required weekly controlled drug checks. Maintain evidence that verbal orders are confirmed by two persons.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				order records sampled.		
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.3	Where required by legislation there is an approved evacuation plan.	PA Low	Eight of the 44 staff have not attended a fire training and trial evacuation at least once in the last twelve months.	Ensure that all staff attend a fire training and trial evacuation at last once a year.	90
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 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.	PA Low	Staff interviewed are unclear regarding the difference between a restraint and an enabler in terms of voluntary use.	Provide sufficient education on restraint/enabler use regarding voluntary use.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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:

Communication processes, including open disclosure policy of the facility, are explained to new residents by the manager during admission. The process is included in the staff handbook for new staff, and included in the orientation program. There is evidence of good communication with resident / family from six of six resident/family interviews, in five of five resident files reviewed and in three of three adverse event records reviewed.

Translation can be provided where needed but has never been required. Interpreters are available via the District Health Board. Languages spoken by staff include English, Maori, Pilipino, Columbian, Kiribatian and Afrikaans. Interpreters have not been required.

The previously identified area of improvement regarding signed service agreements (1.1.10.4) has been adequately addressed. Resident agreements are sighted in three out of four resident records sampled. The remaining resident agreement is that of a resident who was recently admitted and the agreement is with the family member.

This is confirmed in interviewed with the family member, who states they are happy with the agreement and will have it signed and returned as soon as possible. Relevant 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.

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: Not Audited
Evidence:

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained 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.)

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: PA Low

Evidence:

The complaints process, forms and a drop box are displayed in the entrance of the facility. The complaints process is included in the residents' booklet for new residents and the resident admission agreement. Residents and family interviewed are aware of the process and how to make a complaint. The complaints register is kept up to date with date of complaint, type of complaint, date of response, records of the letter or complaint form, and the manager's investigation. Improvement is required to ensure that a record of the action taken and the complainant's response are documented in the complaints record. Relevant 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:

Corrective Action:

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

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.

Attainment and Risk: PA Low
Evidence: Complaints records reviewed indicate that the actions taken are not followed up and the complainant's response to the outcome are not documented in the complaint records.
Finding: Complaints records are not always completed with regards to follow up or to the complainant's response to the investigation.
Corrective Action: Ensure that complaints records are always completed with regards to follow up and include the complainant's response to the investigation.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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: The vision mission and goals are displayed in the front entrance and were last reviewed in April 2012. They are appropriate for an aged care facility providing residential care at rest home and hospital care levels. The vision and goals are included in the resident handbook and the orientation program for new staff. The facility manager is a registered nurse with a current practicing certificate and previous experience in clinical care and health services management. There is evidence that she regularly undertakes relevant ongoing education. She is assisted by a senior registered nurse who oversees the day to day care of the residents. Relevant 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.

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 1.2.3: 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 Moderate
Evidence: There is a documented quality and risk management system in place that was last reviewed in April 2012. Quality and risk management requirements are included in staff

orientation and included in staff meetings. Up to date service delivery policies, procedures and guidelines are available to staff. Specialist advice is available from the DHB clinical nurse specialist. There is a process in place to identify and control documents to ensure that out of date documents are removed from the system.

Manager and five staff interviews indicate that senior and general staff meetings are held monthly where issues relating to infection control, health and safety, adverse events, complaints, internal and external audits, consumer feedback, internal audits, staffing and occupancy are reviewed and discussed but there are no minutes to verify what has been discussed or decided. Improvement is required to ensure that records of staff meetings are consistently maintained and documented in a format that enables verification of the information provided and discussed and any feedback received. Actions needed to remedy a deficit and prevent recurrence are identified in records of adverse events, complaints and internal audit reports. The manager monitors implementation and ensures that it is effective.

There is a documented risk management plan that includes health and safety, hazard management and emergencies. Improvement is required to ensure that the risk plan addresses clinical risks relating to staffing and staff competence, contractual compliance, resident safety and clinical care. Improvement is also required to ensure that the generic hazard register is modified to address the actual and potential hazards at Warkworth Hospital. Relevant 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.

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 1.2.3.3 (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.

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 1.2.3.4 (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.

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

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

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 1.2.3.6 (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.

Attainment and Risk: PA Low
Evidence: Manager and five staff interviews indicate that senior and general staff meetings are held monthly where issues relating to infection control, health and safety, adverse events, complaints, internal and external audits, consumer feedback, internal audits, staffing and occupancy are reviewed and discussed but there are no minutes to verify what has been discussed or decided.
Finding: Minutes of reviews of quality issues discussed at senior management meetings and at staff meetings are not maintained to provide a record verifying what has been reviewed, discussed or decided.
Corrective Action: Ensure that minutes of reviews of quality issues discussed at senior management meetings and at staff meetings are maintained to provide a record verifying what has been reviewed, discussed and decided.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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.

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 1.2.3.8 (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.

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 1.2.3.9 (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: PA Moderate
Evidence: There is a generic hazard register in place but not all the potential or actual hazards evident at the facility have been included in the register. There is no system in place for regular reviews for the hazards or the effectiveness of the controls that are in place. The risk management plan addresses health and safety issues, environmental risks and emergencies. Risks related to security, equipment failure, business continuity, and recovery, staffing, staff competence, information management, contractual compliance, financial management, clinical care and resident behaviour, are not addressed.
Finding: The documented hazard management system is generic and has not been adapted to the situation at the facility. Hazard checks have not been implemented. The documented risk management plan does not address clinical risks relating to staffing and staff competence, contractual compliance, clinical care or resident safety, for example the risk to residents from the behavior of other residents.
Corrective Action: Extend the risk management plan to include all areas of clinical risk that are relevant to the services provided. Identify and document the hazards and controls that are relevant to the service, and audit the effectiveness of the controls at least annually.
Timeframe (days): 90 (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:

Manager interview indicates awareness of all situations where it is required to report to the Ministry of Health, government bodies such as ACC, the DHB, public health officer, police and other agencies. There have been no events requiring such reporting since the last audit. Processes for recording and responding to adverse events are clearly documented. Five staff interviews indicate they are aware of their responsibilities in relation to adverse events. Individual records are maintained for each event. Five of five sampled records include details of the event, investigation, causes and remedial/ preventive actions taken, and notification of the family, with sign off by the manager. The previous improvement required in relation to completion of family contact forms has been addressed. Relevant 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: PA Low
Evidence: Professional qualifications are checked during employment processes. Continuing certification for RNs and doctors are verified annually and recorded. Employment processes are documented and comply with good human resources practice. Review of staff files indicates that the previous improvement required in relation to maintaining signed job descriptions in staff files has been addressed. Seven of seven staff employed since the last audit have evidence of interviews. Manager interview indicates that reference checks are done but improvement is required to ensure that a record is maintained in the staff file. There is evidence that all staff receive an orientation to the facility and to the requirements of their position. Ongoing education program sighted for 2013 and associated training records verify that relevant training sessions are provided. Review of individual staff training records in five staff files indicates that individual records are not consistently maintained up to date. Relevant 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.

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: PA Low
Evidence: Review of the records of the seven staff employed in the last 12 months indicates that records of telephone reference checks are not maintained.
Finding: Records of telephone reference checks are not maintained in staff files.
Corrective Action: Ensure that records of telephone reference checks are maintained in staff files.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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: PA Low
Evidence: The 2012 and 2013 ongoing education programs and associated training records verify that training sessions required by the ARC have been provided at least once in the last two years. Review of individual staff training records in five staff files indicates that individual records are not consistently maintained and up to date.

Finding: Individual staff training records are not kept up to date in staff files.
Corrective Action: Maintain individual staff training records up to date.
Timeframe (days): 90 (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

Attainment and Risk: PA Low
Evidence: There is a documented process for the allocation of staff that complies with contractual requirements, and is suitable for the layout of the facility and the level of care provided. At least one registered nurse is on duty at all times. There is evidence in rosters reviewed and from five of five staff interviews that numbers and skill mix are sufficient to maintain safety and deliver the care required seven days a week, 24 hours a day. Staff report that prompt on call back up is provided by the manager if required. Review of adverse event records and staff interviews indicate there have been no issues relating to staffing since the last audit. Improvement is required to ensure that records of management and staff meetings are consistently maintained and documented in a format that enables verification of the information provided and discussed and any feedback received. Relevant ARC requirements are met.

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: PA Low
Evidence: Manager and five staff interviews indicate that senior and general staff meetings are held monthly where staffing is reviewed and discussed but there are no minutes to verify what has been discussed or decided. Improvement is required to ensure that records of staff meetings are consistently maintained and documented in a format that enables verification of the information provided and discussed and any feedback received.
Finding: Records of management and staff meetings are not maintained and documented in a format that enables verification of the information provided and discussed and any feedback received.
Corrective Action: Ensure that records of staff meetings are consistently maintained and documented in a format that enables verification of the information provided and discussed and any feedback received.

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

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

Attainment and Risk: FA

Evidence:

Each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and reviewed by a registered nurse with a current practicing certificate. Daily interventions and support with activities of daily living are implemented with the help of trained care givers and allied health providers.

Timeframes for service delivery are defined and met as evident in four out of four files sampled. An initial nursing assessment is performed on admission by the registered nurse and a medical assessment conducted by the GP within forty eight hours. Following this the long term care plan is developed and implemented to meet the identified needs and goals of the resident. Short term care plans are also developed in the event of a wound or infection.

The multi-disciplinary process ensures a comprehensive review of care is completed every six months. This process includes the involvement of the resident and family (where applicable). The required reviews are sighted in files sampled and have been conducted within the defined timeframe.

Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement and daily handovers ensure day to day continuity.

Care givers are allocated a case load each morning. Records of caregiver patient lists and handover reports provide evidence of continuity of care and appropriate communication between staff.

Residents are assessed by their GP on entry. Responsibilities for the provision of daily care are identified during the handover reports. Care plans are developed using the nursing process. This involves a comprehensive assessment which identifies individual care needs. From this the care plan is developed. Although the care does not have pre-set headings the care plans sampled are individualised, comprehensive and include the required domains.

Rest home resident file sampled using tracer methodology:

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

Hospital resident file sampled using tracer methodology:

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

The ARC requirements are met.

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: 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 1.3.3.3 (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.

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 1.3.3.4 (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.

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 1.3.6: 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: FA
Evidence: <p>Interventions are documented for each nursing diagnosis/needs and goal. The related action care plan includes interventions. Interventions sighted are comprehensively documented and consistent with good practice. The GP interviewed is satisfied that clinical interventions are implemented in a timely and competent manner. Interventions from allied health providers are also given due consideration.</p> <p>The required nursing response to a change in condition or observation is documented. For example a request from the GP for additional monitoring. Regular observations are also documented. All residents records include a weight chart and a monthly TPR recording chart. There is evidence of temperature monitoring in the event of infection. Bowel charts are also sighted and related records confirm appropriate interventions (in a timely manner) when required.</p> <p>A short term care plan (and required interventions) is also sighted for any variance to 'normal' behaviour. For example in the event of an increase in confusion. Wound care plans include the required assessment and monitoring interventions, as does the short term nursing care plan for a resident with an infection.</p> <p>The ARC requirements are met.</p>

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: 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 1.3.7: 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:

The role of the Diversional Therapist is a full time position, five days per week. The facility has been without a Diversional Therapist (DT) for the past three weeks, however a new DT is scheduled to commence within the next week. Throughout this time the activity programme has been maintained. Interview with the Nurse Manager and a review of the current activities confirms that a sufficient range of planned activities is provided.

Each resident has a diversional therapy admission assessment completed on entry. From this a diversional therapy care plan and goals are developed. Attendance records are maintained and reviewed during the MDT evaluation to ensure that activities remain appropriate and meaningful.

Six out of six resident surveys sighted confirm satisfaction with the activities programme. All residents interviewed (and family members) confirm that appropriate and meaningful activities are provided.

Residents are observed engaging in activities and social interactions during the audit. This includes listening to a care giver play the organ, enjoying visitors, interacting with staff, watching television and playing with the dog. The auditor observes lots of laughter and chatting amongst staff and residents.

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.

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 1.3.8: 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

Attainment and Risk: FA

Evidence:

The multi-disciplinary (MDT) review process ensures a comprehensive review of care is conducted every six months. The MDT includes input from the diversionary therapist, nurse manager, GP, registered nurse and family/whanau.

Any deviation from goals is documented and the care plan updated accordingly. Records sighted include a care plan status change form which is used to identify when reviews have occurred and any additions or amendments made. Achievement towards specific goals is recorded.

Wound care plans and short term care are also evaluated as and when required. Three monthly GP reviews are evident in resident files sampled. Residents and family members state they are involved in the care planning and review process.

The previously identified area of improvement regarding updating care plans when there is on-going and unexplained weight loss (1.3.8.3) has been adequately addressed. Care plans sampled, weight monitoring charts, GP interview and progress notes confirm that weight loss (or gain) is appropriately managed and monitored (refer criterion # 1.3.3.3).

The relevant 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.

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 1.3.8.3 (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.

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 1.3.12: 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 Moderate
Evidence: <p>There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice guidelines.</p> <p>A blister pack medication system is implemented. All medicines are prescribed by the GP using the pharmacy generated medication chart. The service has one GP. All medication charts include photo identification and allergies. Three monthly GP reviews are evident in all records sampled.</p> <p>Medications are safely stored in a locked medication cupboard and medication trolley in the treatment room. Medications requiring refrigeration are kept in a small fridge, however temperature monitoring records and observation demonstrate that the fridge temperature is too cold.</p> <p>There is a small amount of stocked medication kept on site. There is a system in place for stock checks and monitoring of expiry dates. There is a sufficient process for taking verbal (telephone) orders from the GP which requires a two person check, however one out of two verbal orders sighted did not have evidence of a two person check.</p> <p>Standing orders are documented and were last reviewed early by the GP in early 2012. The standing orders now need to be updated to include the 2012 standing orders guidelines.</p> <p>Controlled drugs are stored securely, however there was one example where the weekly check had not been documented.</p>

Medications are administered by the register nurses. Competencies for medication management are implemented and monitored. Records are sighted to verify the process. A lunch time medication round is observed and confirms administration is safely maintained and the administration record is documented. Medication errors are reported and investigated through the adverse event system.

There are no residents who self-administered their own medication.

The remaining ARC requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes a medication reconciliation process on entry (or return) to the facility.

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 Moderate

Evidence:

Standing orders are documented and were last reviewed in May 2012. The standing orders include indications, medicine, dose range, method of administration and contraindications; however they do not include dose range and maximum dose that can be given.

On the day of the audit the temperature of the medication fridge is below freezing. Records over the last month confirm the fridge has consistently been getting colder. The last recorded temperature was 0 degrees.

Controlled drugs are required to be checked weekly by two registered nurses; however there is one controlled drug that had not been routinely checked between the dates 15 October and 10 November 2013. A low risk is allocated as the medication was being administered twice a day every day and a pharmacy check had occurred on 29 October.

Records of two verbal orders are sighted in the 10 medication records sampled. Evidence of two people signing the order was not evident in one of the records sampled.

Finding:

The current standing orders do not fully comply with the 2012 Standing Orders Guidelines. The number of dose(s) which can be given has not been documented for the use of Paracetamol, morphine, nitro lingual spray, loratadine or metoclopramide.

The medication fridge is outside the temperature range required in order to maintain the efficacy of the medication.

Evidence of weekly controlled drug checks have not been consistently maintained.

Evidence of two persons confirming a verbal order has not been maintained in one out of two verbal order records sampled.

Corrective Action:

Amend the current standing orders to include the number of dose(s) for which the standing order is valid.

Maintain the medication fridge at the required temperature.

Maintain the required weekly controlled drug checks.

Maintain evidence that verbal orders are confirmed by two persons.

Timeframe (days): 90 (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.

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

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:

Residents are provided with a well-balanced diet which meets their nutritional needs. The menu is reviewed by a dietician and confirms it is appropriate for the nutritional needs of the older person. Deviations from the menu, occurring as a result of the availability of fresh produce, or in response to individual likes and dislikes, are recorded.

Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. There is a system in place in the kitchen in order to quickly identify special needs.

Residents are weighed monthly and confirm nutritional needs are being sufficiently addressed. Where required, additional nutritional support is documented and appropriate interventions implemented. This includes referrals to a dietician as required. The GP reviews weight charts during medical review.

Residents interviewed are satisfied with the food. The meal service is observed during the audit. Meals are well presented and sufficient in quantity.

The cook is interviewed and has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained.

The ARC requirements are met.

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): (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.

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 1.4.2: 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: FA

Evidence:

There is a planned maintenance programme and the building is well maintained. Furnishings, fittings and floorings are well maintained and suitable for the care and support of elderly, dependent residents. Applicable building regulations and requirements are met. There is a current building warrant of fitness, expiry date 18 July 2014. Monthly fire safety inspections are maintained.

Sufficient equipment and supplies are provided to meet the care needs of the residents. The hoists and weighing scales are functionally maintained and calibrated annually. There is a process in place to ensure that all items of electrical equipment are maintained in a safe condition and to ensure that digital thermometers and sphygmomanometers are calibrated annually. The credentials of tradespersons providing services are available on site.

The interior is all on one level. Handrails are provided in all corridors. There is sufficient space for the use and storage of mobility aids. Some bedrooms have doors to external decks with balustrades. The doors can be freely opened from inside but cannot be opened from outside providing security from intruders.

Enclosed external decks with suitable seating are available for the use of residents. A separate, sheltered area is provided for use by smokers. A ramp with a non-slip surface and handrails leads from the front door to the driveway.

Relevant ARC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

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

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 1.4.7: 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: PA Low

Evidence:

There have been no changes to the physical layout of the building, the exits or the services provided since the fire evacuation scheme was last approved. Fire training and trial evacuations have been held twice in the last twelve months. Improvement is required to ensure that all staff attend a fire training and trial evacuation at least once a year. Relevant ARC requirements are met.

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: PA Low

Evidence:

There have been no changes to the physical layout of the building, the exits or the services provided since the fire evacuation scheme was last approved. Fire training and trial evacuations have been held twice in the last twelve months. Review of staff training records indicates eight of the 44 staff have not attended a fire training and trial evacuation at least once in the last twelve months.

Finding:

Eight of the 44 staff have not attended a fire training and trial evacuation at least once in the last twelve months.

Corrective Action:

Ensure that all staff attend a fire training and trial evacuation at last once a year.

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

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

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

Attainment and Risk: PA Low

Evidence:

Warkworth Hospital uses no restraints and there are two enablers in use. These are both bed rails and are in place at the request of the resident. There is no evidence of restraint use during the audit.

There are adequately documented guidelines on the use of restraints and enablers. Definitions are congruent with the requirements of the Health and Disability Sector Standards. The previously identified area of improvement regarding the provision of de-escalation training has been sufficiently addressed, however there was some confusion amongst staff regarding the difference between a restraint and an enabler and the provision of related training could not be confirmed. There are also guidelines on the management of challenging behaviours.

There have been no reported incidents related to the use of restraints or enablers.

The ARC requirement is met.

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.

Attainment and Risk: PA Low

Evidence:

There are two enablers in use. Both are bed rails and are in place at the request of the resident. There are adequately documented policies on the use of restraint and enablers which include definitions congruent with this standard; however two staff interviewed were not clear regarding the difference in terms of voluntary use and records of related training was not sighted.

Finding:

Staff interviewed are unclear regarding the difference between a restraint and an enabler in terms of voluntary use.

Corrective Action:

Provide sufficient education on restraint/enabler use regarding voluntary use.

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

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

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.

Attainment and Risk: FA

Evidence:

The infection surveillance programme is appropriate for the facility and the level of care provided. Doctors are informed if their resident has an infection. Use of antibiotics and infection rates are monitored. Infections are documented using an event form. These are collated monthly by the infection control nurse. Staff are informed of infection rates through staff meetings. The graphed event reports are displayed, however minutes of staff meeting could not be found on the day of the audit to verify the analysis of infection control data. Refer required improvement in criterion #1.2.3.6.