# Te Kauwhata Retirement Trust Board

## Current Status: 20 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

Te Kauwhata Retirement Trust (Aparangi Village) has 45 beds and provides care to residents requiring hospital and rest home level of care. At this audit there are 34 residents receiving rest home level care and 10 residents receiving hospital level care.

A new care manager had been employed two weeks prior to audit. She previously held the role of clinical co-ordinator. A registered nurse has been designated with responsibility for staff education and resident admissions since July 2013. There have been no significant changes to the land or buildings since the previous audit.

At the last audit there were 19 areas identified as requiring improvement. Eleven of these have been fully addressed. At this audit there were twelve areas identified as requiring improvement. These relate to: open disclosure; corrective action planning; reviewing the hazard register, incident management processes; staff orientation; and ongoing education. Care planning, evaluation of progress in meeting goals, ensuring interventions meet the resident’s needs, medication management practices, staff medication competencies, and identification of individual resident's dietary needs are also areas requiring improvement.

## Audit Summary as at 20 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 |
|  | 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 20 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 20 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. |

### Continuum of Service Delivery as at 20 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. |

### Safe and Appropriate Environment as at 20 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. |

### Restraint Minimisation and Safe Practice as at 20 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. |

### Infection Prevention and Control as at 20 February 2014

|  |  |  |
| --- | --- | --- |
| 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. |  | Standards applicable to this service fully attained. |

# 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:** | Te Kauwhata Retirement Trust Board |
| **Certificate name:** | Aparangi Village Residential Care Unit |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | DAA Group Ltd |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Unannounced surveillance | | | |
| **Premises audited:** | 6 Pilgrim Place, Te Kauwhata | | | |
| **Services audited:** | Medical, Geriatric, Rest home care | | | |
| **Dates of audit:** | **Start date:** | 20 February 2014 | **End date:** | 20 February 2014 |

|  |
| --- |
| **Proposed changes to current services (if any):** |
|  |

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 44 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 10 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 10 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 20 | Total audit hours off site | 18 | Total audit hours | 38 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 55 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

I, XXXXX, Director of Wellington 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 DAAhas in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAAhas 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 DAAhas provided all the information that is relevant to the audit | Yes |
| h) | the DAAhas finished editing the document. | Yes |

Dated Tuesday, 18 March 2014

## Executive Summary of Audit

|  |
| --- |
| **General Overview** |
| Te Kauwhata Retirement Trust (Aparangi Village) has 45 beds and provides care to residents requiring hospital and rest home level of care. At this audit there are 34 residents receiving rest home level care and 10 residents receiving hospital level care.  A new care manager has been employed two weeks prior to audit. She previously held the role of clinical co-ordinator for approximately the two years prior. A registered nurse has been designated with responsibility for staff education and resident admissions since July 2013. There have been no significant changes to the land or buildings since the previous audit.  At the last audit there were 19 areas identified as requiring improvement. Eleven of these have been fully addressed. At this audit there were twelve areas identified as requiring improvement. These relate to: open disclosure; corrective action planning; reviewing the hazard register, incident management processes; staff orientation; and ongoing education. Care planning, evaluation of progress in meeting goals, ensuring interventions meets the resident’s needs, medication management practices, staff medication competencies, and identification of individual resident's dietary needs are also areas requiring improvement. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| Policies and procedures are available to guide staff practice on communication, open disclosure. Family and residents confirmed they are happy with communication processes and feel well informed. Evidence of open disclosure occurring following reported incidents is not consistent and this is an area requiring improvement.   A complaints register is being maintained. Complaints are documented, investigated and followed up in a timely manner. The area identified as requiring improvement at the last audit now meets the standard. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| The general manager is an experienced mental health registered nurse (with a current practising certificate) who has held a variety of senior management roles in the health sector. The care manager is also a registered nurse and is responsible for the day to day care needs of the residents. Both managers are attending relevant ongoing education.  The organisation's quality and risk systems includes: complaints and compliments management; internal audits; family satisfaction surveys; and the inaugural family focus group meeting occurred in December 2013. Processes to monitor how the service meets the quality and risk objectives are detailed. The area identified as requiring improvement at the last audit now meet the criterion.  All policies and procedures have been reviewed and updated with the assistance of an external contractor. Document control processes are in place. The two areas identified as requiring improvement at the last audit now meet the standards.  There is a process for the reporting and management of new hazards. The organisation's hazard register has not been reviewed since June 2011. This remains an area requiring improvement. An organisation risk register has been developed and now meets the requirements of the standards.   Staff are required to report adverse events/incidents. Appropriate events are being reported and the results analysed and reported monthly. The area identified as requiring improvement at the last audit now meets the standards. A new area for improvement is identified in relation to a process of monitoring incident reports when they are returned to staff for more information. While corrective actions are being undertaken in response to complaints and audits, corrective action plans are not consistently developed or at times sufficiently detailed following reported incidents. The corrective action planning process continues to be an area identified as requiring improvement.  Staff interviewed report being informed of quality and risk issues, including adverse events, use of restraint and enablers, infections and audit results, via staff meetings and/or shift handovers.   The recruitment processes includes interviews and reference checks and validating qualifications (where applicable). The annual practising certificates are available for all applicable health professionals (including those contractors). Staff performance appraisals are undertaken annually. These now meet the requirements of the standards. While staff are required to complete an orientation programme records evidencing staff are completing requirements are not consistently available in staff files reviewed. This is a new area requiring improvement. Staff participate in ongoing education provided both onsite and offsite. Education is provided to meet individual resident’s needs, however an overall education plan has not been developed. The fire evacuation drill is overdue. These issues require improvement.  There is a registered nurse on duty at all times. Staff and managers interviewed confirm staffing is adjusted where required for changes in resident numbers or acuity. There is at least one staff member with a current first aid certificate on duty at all times. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| The residents and family interviewed report a very high level of satisfaction with the quality of care provided at the service. Service is provided by suitably qualified nursing and care staff. The assessment, planning, provision and evaluation of care are provided within time frames that comply with contractual requirements. The area identified as requiring improvement now meets the standards.  Documented interventions related to resident care are not always congruent with assessment findings. Evaluations are undertaken at least six monthly but do not identify the degree to which interventions are assisting residents to meet their nominated goals. Changes to resident care is well understood by staff but not always documented on the care plan. These three areas require improvement.   The activities programme supports the interests, needs and strengths of the residents. The residents and families interviewed express satisfaction with the activities provided. This now meets the standards.   Policy and procedures clearly describe a safe medicine management system which is implemented related to medicine administration and documentation processes. Some expired medicines were not returned to the pharmacy and not all documentation has been completed to identify if staff who administer medicines have current competencies. These are two areas require improvement.   Residents and family/whanau state the food is very good and they express a very high level of satisfaction with the food and fluid offered at the service. The menus are appropriate to the resident group and have been reviewed by a dietitian. The information sighted in residents’ dietary profiles and the information found in the kitchen is not consistently the same and this requires improvement. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current building warrant of fitness. Electrical safety test and tag labels are present on the electrical equipment checked at random. Clinical equipment checked has current performance monitoring labels. Chemicals are sighted as stored securely in locked rooms and are in clearly labelled containers. The areas identified as requiring improvement at the last audit now meets the standards. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The safe and appropriate use of restraints/enablers policy includes the definition of enablers which is congruent with the requirements of the standards. Approved enablers are identified. Staff interviewed are able to clearly detail the difference between restraints and enablers, identify the approved enablers and the monitoring requirements when enablers are in use.  During audit five residents have enablers in use. The use of enablers is documented in the resident file sampled.  Restraint minimisation is included in the inservice programme. Fourteen staff attended the inservice held in March 2013. |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The results of surveillance of infections are analysed and reported to staff and management. Where trends are identified, the service implements actions to reduce the rates of infections |

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 9 | 0 | 5 | 3 | 0 | 0 |
| **Criteria** | 0 | 28 | 0 | 9 | 3 | 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 | 61 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Open disclosure is not documented as occurring for all applicable incident forms sighted during audit. | Ensure open disclosure occurs in a timely manner for all applicable events and records are available to demonstrate this. | 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 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 Low | Corrective action plans are not always developed for incidents/accidents (adverse events) events in a timely manner following adverse events and do not always include all areas requiring improvement. | Ensure corrective action plans are sufficiently detailed to include all areas requiring improvement, are implemented and monitored for effectiveness. | 180 |
| 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 Low | The hazard register has not been reviewed since July 2011. | Ensure the hazard register is reviewed in a timely manner. | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is no process to record details of incident reports which are returned to the RN’s for additional information to be recorded and whether the completed forms are subsequently returned and included in monthly incident data. | Develop a system to identify and record accurately the incident reports returned to the RN to ensure all incident reports are included in data analysis. | 180 |
| 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 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Records are not available to demonstrate that five staff whose file reviewed and employed between August 2012 and November 2013 have completed the organisations orientation programme | Ensure all staff complete the organisations orientation programme in a timely manner and records are available to demonstrate this. | 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 | An education plan detailing what education is required to be completed in order to ensure compliance with legislative requirements, the ARRC contract and H&DS standards has not been developed. The fire evacuation drill is noted to have been last completed on 3 July 2013 and is overdue. | Ensure education is planned to ensure legislative, contractual, resident needs and health and disability sector standards are met. | 180 |
| 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 | One resident has a dietary profile which does not match the information shown in the kitchen. One resident has an assessment which shows  1. That they are low falls risk and the care plan shows they are a high falls risk  2. assessment identifies stoma cares required but this does not show on the care plan. Cares are clearly identified as being undertaken daily in the resident progress notes.  3. The dietary profile and care planning information are different. This inconsistency is found throughout all files reviewed and another example relates to a behaviour management assessment being undertaken for a resident with no mention of this on the care planning information. In three of the nine files no updated assessment information related to the resident’s current falls risk does not correspond with information shown on the care plan. | Ensure interventions shown on care planning are consistent with residents assessed needs. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Documented evaluations do not indicate the degree of achievement or response to the interventions that have been put in place or the degree of progress residents have made towards meeting their identified goals. It usually just repeats the interventions and is task focused not resident focused. This is an area that was identified for improvement in the previous audit and remains open. | Ensure evaluations indicate the degree of achievement or response the resident has made towards the stated goals and if interventions are working as expected. | 90 |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | Dietary needs shown in the care plan do not match information found in the kitchen and is not consistent with residents’ immediate needs. Examples include a care plan which identifies the resident is having a nutritional supplement which was stopped two months prior to audit. Two files of the nine reviewed show that assessed falls risk rating does not match what is shown on the care plan. | Ensure where progress is different from expected correct information is shown on the residents care plan. | 180 |
| 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 Low | Three expired medicines dated with an expiry of March 2013 were found in the medication cupboard. They were two lots of antibiotics and one container of prednisone. All three lots of medication were prescribed for individual residents. They were discarded and placed in the container to be returned to the pharmacy on the day of audit. | Ensure all medicine management systems described in policy and legislation is complied with. | 180 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | A list details the names of 14 staff that are medication competent with assessments reported to have been completed in the last twelve months. A review of records identifies some staff have not completed all components or the records are in-sufficiently detailed. Four medication competency assessments contain the staff members name only and no additional information is completed; some records contain ticks against criteria but are not dated or signed by the person undertaking the competency assessment. | Ensure sufficiently detailed documentation is available to verify that all service providers responsible for medicine management have completed all components of the competencies, and can safely administer medications. | 90 |
| 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 |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.2 | Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | Dietary profile information used to inform care planning is not congruent with information found in the kitchen related to resident food needs, likes and dislikes. | Ensure all individual resident nutritional needs are documented in a consistent manner so that all information is congruent. | 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:**PA Low |
| **Evidence:** |
| While residents and family confirm there is open communication with staff; documentation evidencing open disclosure is not present for all applicable incident reports sampled. This is an area requiring improvement.  Two of two registered nurses (RN) and five of five caregivers interviewed advise all current residents can speak and understand English. If translators are required; this is reported to be organised via with the DHB.  The aged related residential care (ARRC) contract 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:**PA Low |
| **Evidence:** |
| There is an open disclosure policy dated July 2013. This identifies that residents and their support persons have the right to open disclosure. Guidance on what open disclosure is and how open disclosure is to occur are included in the policy.  There is evidence of open disclosure occurring however this is not always consistent or at times timely. The incident reporting form includes an area for staff to identify if the family have been informed of the event. Where the answer is no a rationale is to be provided. Six incident reports sighted for the period 31 January 2014 to 3 February 2014 do not have documentation that family have been informed. A review of the progress notes of the applicable residents does not contain documentation evidencing the family were informed in relation to five of these six incidents. One of the events is noted in the staff communication book with a request for staff on the morning shift to contact the family. This contact had not been undertaken. The care manager (CM) advises incident forms are not normally filed unless the area noting open disclosure has occurred is completed. A review of some completed and filed incident forms selected at random for November and December 2013 identifies that family have been informed for the majority of sampled events but not all. This is an area requiring improvement. Two of two registered nurses (RN) and five of five caregivers interviewed advise the RN is responsible for ensuring open communication occurs with family in a timely manner. All six residents (three hospital and three rest home) and all five family interviewed confirm they are happy that staff are communicating in an open manner with them. |
| **Finding:** |
| Open disclosure is not documented as occurring for all applicable incident forms sighted during audit. |
| **Corrective Action:** |
| Ensure open disclosure occurs in a timely manner for all applicable events and records are available to demonstrate this. |
| **Timeframe (days):**180*(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 1.1.13: 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:** |
| There is a concerns and complaints policy dated July 2013. The policy notes that right of residents, significant family or others to make a complaint. The process of documenting, acknowledging and responding to complaints are detailed and align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers' Rights (the Code).  All seven staff interviewed (five care givers and two RNs) are able to verbalise their responsibilities in relation to the complaints process.  All six residents and five family members interviewed confirm they are aware of the complaints process and are happy with services being provided.  The complaints register is sighted. This includes details of all complaints received, timeframes and details of actions undertaken. The area identified as requiring improvement at the last audit now meets the criterion.   The complaint received from the Health and Disability Commissioner in August 2012 remains open. One complaint from early 2013 remains open in the register. The general manager is able to evidence that there has been ongoing communication occurring in an endeavour to resolve this complaint. The complaint remains open as the management team require a decision by an external organistion in order to determine what if any further actions will be taken in response to this complaint. The complaints related documentation sighted at audit.  ARRC contract 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:**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 1.2: 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 statement and philosophy of the organisation is documented in the business plan for 2013 to 2015 period. The strategic direction, goals (four) and organisation values are clearly identified.   A strategic planning day was scheduled to be held by the GM, CM and board on the day of the unannounced audit. The GM advises the agenda includes a review the board of trustees (BOT) constitution, previous board objectives, challenges/risks, property/environment, marketing and future service development opportunities. The GM advises an external facilitator was attending the strategic planning day and copy of the agenda sighted. The GM advises a review of the organisations vision and philosophy would have been a component of this meeting.  The general manager was appointed to this role for Te Kauwhata Retirement Trust Board on the 25 March 2013. A copy of the signed employment agreement and job description (JD) are sighted. The GM advises prior to being employed in the GM roles she held senior management positions for Odyssey House, Healthcare New Zealand, Canterbury DHB and Richmond Fellowship and this is verified in the CV sighted during the previous audit in May 2013. The GM is a RN with a current APC (sighted) expiry December 2014. The GM's scope of practice is mental health nursing.  The care manager (CM) has been in the role for two weeks. The CM was initially employed as a RN in the facility and subsequently became the clinical coordinator – a role held for approximately the past two years. Prior to this the CM has worked in emergency departments for nine years including five years at Waikato Hospital. She is a RN with a current practising certificate (APC) which is sighted. Both the GM and the CM have attended more than eight hours of education related to the management of an aged care facility in the last twelve months as required to meet the ARRC requirements. Email confirmation of bookings or certificates of attendance at various inservice programmes, study days and conferences sighted.   The CM's job description includes responsibilities to ensure the day to day care needs of the residents are met.    The ARRC contract 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):***(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:** |
| Te Kauwhata Retirement Trust has a quality and risk programme which includes (but is not limited to): - complaints / compliments - resident satisfaction surveys - resident meetings - family satisfaction surveys - family focus groups - internal audits - incident reporting (including near miss events) - monitoring residents for infections - monitoring the use of restraints and enablers - policy and procedure review - staff education.  There is a documented quality and risk management plan which notes a quality improvement philosophy. Objectives and management controls are detailed. The plan identifies how the effectiveness of the plan will be monitored and reported. The area identified as requiring improvement at the last audit now meets the standards.  Seven of seven staff interviewed (two RNs and five care givers) interviewed confirm they are advised of relevant quality and risk issues and adverse events during shift handovers or via monthly staff meetings. The minutes of the three most recent monthly staff meetings are sighted. Minutes includes discussions on staff changes, infection rates, education, activities, uniform, equipment and care issues for individual residents. Some incidents are noted as being discussed. While staff advise they are informed of overall incident rates and trends the minutes do not clearly include these discussions or refer to information. There are opportunities to enhance communication by more clearly including this data.  The minutes of the three most recent quality assurance / quality improvement (QA/QI) and leadership weekly meeting sighted. These include more specific discussions on adverse events, complaints, restraints and enablers in use, education and required equipment. Data related to residents with infections is also discussed. Some meeting minutes have corrective action plans attached which includes actions, by whom and when. Corrective action plans following adverse events are being developed however are not always sufficiently detailed to include all relevant areas and this is an area continuing to require improvement.  The GM advises the first family focus group meeting occurred in December 2013. Twelve family representatives attended and the outcomes identified as being very worthwhile/positive. A family satisfaction survey was undertaken in October 2013. Nine responses received and the summarised findings reviewed at audit. Overall the feedback is positive. A corrective action plan was unable to be located at audit for the areas identified as requiring improvement. The CM advises individual follow-up with respondents occurred by the previous care manager.  Since the last audit an external contractor has been contracted to assist the organisation in reviewing and updating policies and procedures. The infection prevention and control, restraint minimisation and service delivery related policies have been updated and recently issued to staff. The policies sighted at audit are clear and align with current accepted practice or legislative requirements. The remaining policy documents have been reviewed and updated and are scheduled for imminent release. These documents sighted at audit. There is a documented policy that details the processes related to document review and includes document control processes. Changes in policies are discussed at the leadership forum. Currently the master copy of policies are available electronically. There is one paper copy in the staff office and one is also held by management. The two areas identified as requiring improvement at the last audit now meet the standard. An internal audit schedule is maintained and includes audits related to service delivery, documentation, environment and equipment. All required audits are noted to have been undertaken for the three months (November 2013 to January 2014) sampled. Audit reports selected at random and reviewed including environmental audits and promoting continence audit. The audits are evaluated and identified improvements required are noted and corrective action plans developed. The internal audit schedule for 2014 has been reviewed and streamlined to focus audit activities on monitoring more specific/meaningful components of service delivery. New audit templates have been developed and a sample sighted. There are processes in place for staff to report new hazards. New hazards are being reported and managed. The organisations hazard register has not been reviewed since July 2011 and remains an area requiring improvement. The GM has developed an organisation risk register. There are documented risk mitigation strategies noted and a risk rating is noted. The area identified as requiring improvement at the last audit now meets the criterion.  Not all ARRC contract requirements are met excluding D 19.3 ii and D 19.4b. |

##### 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:**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 1.2.3.7 (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:**PA Low |
| **Evidence:** |
| Corrective action plans are being developed and are monitored via the care manager and at meetings. Corrective action plans are developed following scheduled audits and in relation to complaints.  A sample of corrective action plans developed following adverse events do not have investigations noted and/ or the corrective action plan does not include all areas requiring improvement. For example in relation to medication events for a resident admitted for respite care and a resident who unexpectedly left the facility during the night. Corrective action planning continues to be an area requiring improvement. |
| **Finding:** |
| Corrective action plans are not always developed for incidents/accidents (adverse events) events in a timely manner following adverse events and do not always include all areas requiring improvement. |
| **Corrective Action:** |
| Ensure corrective action plans are sufficiently detailed to include all areas requiring improvement, are implemented and monitored for effectiveness. |
| **Timeframe (days):**180*(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 Low |
| **Evidence:** |
| There are processes in place for staff to report new hazards. Where new hazards are reported mitigation strategies are being implemented. This is verified during audit. Records identify the organisation hazard register has not been reviewed since July 2011 and remains an area requiring improvement in relation to the hazard register. The organisation policy identifies environmental hazards will be reviewed six monthly.   The GM has developed an organisation risk register which includes (but is not limited to) the following categories of hazards; clinical, human resource, financial/management, natural disaster/emergency contingency plan, adverse events, infection prevention and control and health and safety hazards. There are documented risk mitigation strategies noted and a risk rating is noted. The risk management programme is based on national standards. There is evidence of discussion of relevant risk at the monthly board meeting minutes and/or in the monthly GM board reports sighted. This component of the area identified as requiring improvement at the last audit now meets the criterion. |
| **Finding:** |
| The hazard register has not been reviewed since July 2011. |
| **Corrective Action:** |
| Ensure the hazard register is reviewed in a timely manner. |
| **Timeframe (days):**180*(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:**PA Low |
| **Evidence:** |
| The adverse event reporting policy provides guidance for staff on the type of events that are required to be reported and the process. When forms are returned by the CM to staff for further information; there is currently no process in place to ensure the forms are subsequently returned and included in adverse event data analysis. This is an area identified as requiring improvement. The number of incidents occurring are being categorised and reported each month. The GM and CM advise this process is continuing to be reviewed to ensure data is collected and collated in a more meaningful way. Appropriate events are being reported via the incident reporting system. The areas identified as requiring improvement at the last audit now meets the criterion.  The GM is able to identify the type of events that are required to be essentially notified and who notifications are to be made to. An essential notification has been made to the District Health Board (DHB) and Ministry of Health (MOH) in relation to an event that was reported to the police. An essential notification is reported to have been made to the MOH in relation to the recent change in care manager.   ARRC contract 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:**PA Low |
| **Evidence:** |
| The adverse event reporting policy (July 2013) details the requirement for staff to report adverse events and the associated processes. Seven staff comprising five caregivers and two RNs are able to identify the type of events that are required to be reported including medication errors, falls, skin tears/bruises, unplanned resident absence, episodes of challenging behaviour and ‘anything untoward or out of the ordinary’. Incident reports are sighted completed for relevant events. The area identified as requiring improvement at the last audit now meets the standards.  A number of completed incident report sighted dated within the last three months. The majority have an investigation and corrective action plan noted. A number do not have sufficiently detailed investigations documented as yet or corrective action plans documented for all applicable areas that require improvement. This is raised as an area requiring improvement in 1.2.3.8. The CM advises incomplete incident reports are returned to the RN’s to be completed. The incident reports are not numbered or entered onto the incident register until the CM determines the documentation is complete. There is currently no process to identify which incident reports are returned to staff and when this occurs. Nor is there a process to verify all applicable forms are subsequently completed/returned and included in monthly incident/adverse events statistics. This is a new area identified as requiring improvement.  The GM and CM advise they are continuing to review the incident reporting form and analysis process to obtain more meaningful data to assist with prevention strategies. Changes made since the last audit discussed. The monthly incident analysis for 2013 sighted.  Seven staff including five caregivers and two RNS advise they are informed of reported events in a timely manner via shift handover and monthly staff meetings. This is verified during observation of handover during audit. |
| **Finding:** |
| There is no process to record details of incident reports which are returned to the RN’s for additional information to be recorded and whether the completed forms are subsequently returned and included in monthly incident data. |
| **Corrective Action:** |
| Develop a system to identify and record accurately the incident reports returned to the RN to ensure all incident reports are included in data analysis. |
| **Timeframe (days):**180*(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:**PA Low |
| **Evidence:** |
| Policy documents provides the framework for recruitment/human resources and ongoing staff education requirements. A review of ten staff files (the sample size is expanded at audit) identifies that staff are required to complete an application, interviews are conducted and reference checks for the successful candidate obtained. Interview and reference check records are not present in one staff members file (employed in May 2013). The CM and GM are unsure why this information is not available. The new CM stated the organisations policy and demonstrated appropriate records have been documented for staff recruited since her employment. The CM is observed to receive a phone call during audit in relation to a request (made the previous day) for a reference for a prospective staff member. Reference information is obtained and documented on a template form. All ten staff files contain a signed employment agreement and job description. Records are not available to demonstrate that five staff whose file reviewed and employed between August 2012 and November 2013 have completed the organisations orientation programme. This is a new area requiring improvement.  Practising certificates are available for all RNs, three pharmacists, one general practitioner (GP), one podiatrist and one physiotherapist. The area identified as requiring improvement at the last audit now meets the standard.  A template is provided for staff performance appraisals which are required to be completed annually. Performance appraisals completed in the last twelve months are sighted in the staff files of the five staff employed for more than a year. The CM maintains a list of when performance appraisals were last completed for quick reference (sighted). Eight staff appraisals are due and are currently in progress (sighted). The area identified as requiring improvement at the last audit more meets the standards.   Ongoing education programme includes monthly in-services, competency assessment programme and the ACE aged care education programme. Whilst education is being provided, a plan has not been developed to ensure legislative, contractual and other requirements are identified and met. The fire evacuation drill last occurred on 2 July 2013 and is overdue. This is a new area requiring improvement.  There are competency workbooks that caregivers are required to completed. Not all applicable staff have sufficiently documented medication competency assessments in the last 12 months. This is raised as an area for improvement in 1.3.12.3.  ARRC contract requirements are met excluding D 17.6 and D 17.8. |

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

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

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

|  |
| --- |
| **Attainment and Risk:**FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):***(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:**PA Low |
| **Evidence:** |
| An orientation is required for all staff. Staff interviewed (two RNs and five care givers) confirm the orientation is detailed and includes orientation to the facility, emergency procedures, staff and managers, policies and procedures and individual residents' care. There is an induction book that is to be completed during the orientation. The orientation programme includes shifts on morning and afternoon shifts and in all areas of the rest home / hospital. Staff report they are buddied with a senior caregiver. The staff report the orientation programme provided as being ' very good'. Records are not available to demonstrate that five staff whose file reviewed and employed between August 2012 and November 2013 have completed the organisations orientation programme. This is a new area requiring improvement. The sample size was increased to include more staff employed in 2013 when records are not available in the initial staff files employed during this period. |
| **Finding:** |
| Records are not available to demonstrate that five staff whose file reviewed and employed between August 2012 and November 2013 have completed the organisations orientation programme |
| **Corrective Action:** |
| Ensure all staff complete the organisations orientation programme in a timely manner and records are available to demonstrate this. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.7.5 (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:** |
| Since July 2013 a RN has been allocated responsibility for the staff education programme and resident admissions. The RN is responsible for identifying individual resident care needs and ensuring staff involved with service delivery are appropriately trained. This is noted to be occurring and feedback from the five care givers and two RNs interviewed is very positive about the education opportunities provided. The educator/RN maintains records of attendance and these are sighted. At least nine caregivers have completed one or more industry approved qualifications. The certificates of completion are displayed in the reception area, or qualification noted in the staff files reviewed. The CM has a number of certificates for external courses that have been received but not yet displayed (sighted). One of the caregivers interviewed is an assessor and identifies a number of staff are currently working through modules.  Ongoing education programme includes monthly in-services, a competency assessment programme and the ACE aged care education programme. Whilst education is occurring and future topics are scheduled in the diary, an education plan detailing what education is required to be completed in order to ensure compliance with legislative requirements, the ARRC contract and H&DS standards has not been developed. The educator/RN acknowledges during discussion that she is unaware of the requirements of the ARRC contract. The fire evacuation drill is noted to have been last completed on 3 July 2013 and is overdue.  Records are sighted detailing when staff attended the following education including (but not limited to): first aid, fire evacuation procedures, palliative care, restraint minimisation and safe practice/challenging behaviour, Huntington’s chorea, safe food handling and infection prevention and control. A number of staff have completed some of the nine modules provided by Hospice related to palliative care |
| **Finding:** |
| An education plan detailing what education is required to be completed in order to ensure compliance with legislative requirements, the ARRC contract and H&DS standards has not been developed. The fire evacuation drill is noted to have been last completed on 3 July 2013 and is overdue. |
| **Corrective Action:** |
| Ensure education is planned to ensure legislative, contractual, resident needs and health and disability sector standards are met. |
| **Timeframe (days):**180*(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:**FA |
| **Evidence:** |
| The 'staffing policy' is dated as developed in July 2013. The policy references staffing requirements to the ARRC contract. The care manager is responsible for ensuring staffing numbers and skill mix is appropriate. The CM advises a review of staffing will occur and a decision made as to whether the role of clinical care coordinator will continue or not.  The current roster sighted at audit is documented for the period Tuesday through to Monday (weekly roster) identifies:   - there is a RN on duty every shift. - the CM works weekday morning shifts and is on call when not on site.  - where a staff member has called in sick or otherwise not able to attend their rostered shift, replacements are noted on the roster sighted. Seven staff interviewed (two RNs and five caregivers) confirm staff are replaced if unable to attend their shift. - the RN responsible for staff education and resident admissions work 9 am to 5 pm four weekdays each week - at least one staff member with a current first aid certificate is on duty every shift - residents with higher care needs are allocated on morning and afternoon shifts to an identified team of staff who are responsible for their care regardless of where the resident is located within the facility. - staff interviewed and the care manager verify where the care needs of residents have increased additional staff hours are rostered. This may include the staff rostered on shorter hours working longer hours or a full shift. The five caregivers and two RNs interviewed provided an example of this occurring.  Morning: One RN for the full shift 7.00 am to 1.30 pm = three caregivers 7.00 am to 3.15 pm = two caregivers 7.00 am to 3.30 = one caregiver  Afternoon: One RN for the full shift 3.00 pm to 9.30 pm = two care givers 3.00 pm to 11.15 pm = two care givers Caregivers on the morning and afternoon shifts have allocated areas/residents for whom they are responsible for. The allocation process is sighted.  Night: One RN for the full shift One experienced caregiver works 11.00 pm to 7.15 am.  Diversional Therapist: Works 8.00 am to 4.00 seven days a week. Receptionist: 8.30 to 3.00 weekdays  There are dedicated staff hours in the kitchen laundry and cleaning services.  The CM and a RN interviewed confirm there is always a minimum of two staff in the facility at all times.   Six of six residents and five of five family members interviewed confirm staff provide care in a timely manner. During audit staff are observed to answer call bells promptly.  ARRC contract 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:**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 1.3: 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

|  |
| --- |
| **Attainment and Risk:**FA |
| **Evidence:** |
| Each stage of assessment, planning, provision of care and evaluation is undertaken by suitably qualified staff that are competent to perform their role. The nine of nine (six rest home and three hospital level) residents' files reviewed confirm that the registered nurse (RN) conducts the initial assessment and initial care plan on admission to the service and develops the long term (ongoing) care plan within three weeks. The clinical staff are suitably experienced and ongoing education is offered (refer comments in criterion 1.2.7.5) which is directly related to the role they undertake. All shifts are covered by a RN. Annual practising certificates sighted for all staff that require them.   The initial and ongoing assessments include communication, dietary profile, personal hygiene, senses and sexuality, cultural and spiritual needs, mobility and falls risk, continence, sleep patterns, skin integrity and behavioural management as appropriate. All nine of nine resident file reviews identify that the ongoing long-term care planning process is individualised to show each resident’s needs. As the service is in the process of going onto InterRAI assessments, (to date there are 17 files which have been transferred, two of which are included in the file reviews) staff are currently working with two processes. The educator RN, and the care manager both confirm that as more staff are trained in InterRAI they hope to have all assessments completed using this process within the next year. Care plans show resident needs, interventions put in place and resident nursing and personal goals. The ongoing care plan reviews are conducted at least six monthly, as confirmed in nine of nine file reviews (refer to corrective action requirements in criteria 1.3.6.1 and 1.3.8.2). Resident information is integrated and located in one folder.  Nine of nine resident files reviews identify that the initial medical review is conducted within required timeframes. Ongoing medical reviews are conducted at least three monthly for rest home level care residents and monthly for hospital level care residents. More frequent reviews are undertaken to meet residents changing needs. This was identified as an area for improvement in the last audit related to timeframes not being met. This is now fully attained.  Progress notes are updated each shift. A handover is provided at the start of each shift. An observed handover identifies that adequate information is provided and any care changes are fully discussed. Information in resident progress notes also identifies any required care changes. Interviews with five of five caregivers and three of three RNs (one being the educator) confirms that adequate information is provided to promote continuity of care that is appropriate to meet each residents identified needs.  Six of six residents and three of three family/whānau member interviews report that the care provided meets all their needs.   Tracer one:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer two:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  ARRC 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):***(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.

|  |
| --- |
| **Attainment and Risk:**FA |
| **Evidence:** |
| PA last audit. As timeframes not met. |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):***(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.3.4 (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):***(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:** |
| Nine of nine (six rest home and three hospital) resident long term care plan reviews identify the interventions that are put in place to meet resident needs. The nurse educator, the care manager and the manager along with educational material sighted shows that ongoing education has been put in around care planning processes on a regular basis over the past year. However, the information shown on care plans and assessment findings continue to be areas of inconsistencies. The interventions are not always congruent with assessment findings and as per the previous audit this is an area that requires ongoing improvement.   Interviews with six of six residents (three hospital and three rest home) and five of five family/whānau members confirm that they are satisfied or very satisfied with the care provided and that all their current needs are met. All comments were positive and confirm that staff always go over and above what is required to ensure residents’ needs are catered for. Many examples were verbalised during interviews. |

##### 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:** |
| Care planning information is not consistent with assessment findings. Not all information from updated assessments is transferred on the care plan and not all care planning information can be verified with an appropriate assessment.  This was an area identified for improvement in the previous audit and remains open. |
| **Finding:** |
| One resident has a dietary profile which does not match the information shown in the kitchen. One resident has an assessment which shows  1. That they are low falls risk and the care plan shows they are a high falls risk  2. Assessment identifies stoma cares required but this does not show on the care plan. Cares are clearly identified as being undertaken daily in the resident progress notes.  3. The dietary profile and care planning information are different.  This inconsistency is found throughout all files reviewed and another example relates to a behaviour management assessment being undertaken for a resident with no mention of this on the care planning information. In three of the nine files no updated assessment information related to the resident’s current falls risk does not correspond with information shown on the care plan. |
| **Corrective Action:** |
| Ensure interventions shown on care planning are consistent with residents assessed needs. |
| **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:** |
| During interview with two activities coordinators they are able to show how activities are planned to meet residents individualised needs. There is a set activities plan in place for items which occur on a regular basis such as bingo and a diary is kept of all other activities offered. Resident attendance records are kept in the diary. It was discussed on the day of audit that this may be easier to follow if an attendance sheet was used. The activities coordinators will look at how attendance is reported.   The activities offered to residents match identified social likes and to ensure known strengths, skills and interests are maintained. One example relates to a resident who loves gardening but owing to their medical condition can no longer actively partake in this. The resident identified they would like to do something with their hands and following discussion staff are now teaching the resident to knit.  Interviews with five of five family/whānau members confirm that staff ensure activities offered cater for their relative’s needs. The activities offered cover cognitive, physical and social needs of residents as confirmed during interview with three hospital and three rest home level residents. Resident interviews confirm that overall they enjoy the range and variety of activities that are offered.   The activities coordinators report that activities are well resourced and supported by management. The manager stated that currently the service is in the process of raising money for a six seater custom built cart to assist residents to mobilise around the entire village outdoor area and to go to the local shops more regularly. (This will be driven by a staff member).   Where possible residents' independence is encouraged and one example given relates to a resident who loves to watch sport. They have a large screen television in their bedroom and during important sports matches’ staff assist the resident to invite guests (usually other residents) to watch their television and they have light refreshments provided by the service. Family/whanau and friends are encouraged to partake in all activities and to maintain regular contact with their relatives. Residents are provided with outings on a routine basis. One to one activities are planned to meet the needs of the residents who do not regularly attended the group sessions. Community groups and church services are utilised by the service.   This was an area identified for improvement from the previous audit is now fully attained.  ARRC 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:** |
| One area identified for improvement from the previous audit is now fully attained. This related to documentation not identifying if resident strengths and interests are calved for |
| **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:**PA Moderate |
| **Evidence:** |
| The nine of nine (six rest home and three hospital level care) resident care plan reviews identify that three monthly reviews are undertaken. The service has made a recent change to the frequency of care plan evaluations requirements in policy to show that rest home level care resident evaluations can now be six monthly but that hospital level care residents are to remain on three monthly evaluations. All reviews are conducted by a RN. Care plans are individualised and personalised to each resident. (Refer comments in criterion 1.3.6.1). Any changes in the resident's condition are written in the progress notes and discussed at the staff handover to oncoming staff as observed on the day of audit and confirmed by clinical staff interviews.   Evaluations are task focused and do not indicate the degree of achievement or response to the interventions that are put in place or if the resident’s goals are being achieved. Not all changes to resident care needs are updated on long term care plans. Two areas identified for improvement in the previous audit remain open.   Short term nursing care plans are used to documented temporary changes in the resident's condition. One resident reviewed has a short term care plan for wound management.   Interviews with six of six residents (three hospital and three rest home) and five of five family/whānau members report they are satisfied or very satisfied with the care provided. |

##### 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:**PA Moderate |
| **Evidence:** |
| Evaluations are documented and up dated within required timeframes. Documentation of evaluations is often repeated to show the set goals and not what has been achieved. This was reviewed with the educator/RN who confirmed her understanding of this finding on the day of audit. |
| **Finding:** |
| Documented evaluations do not indicate the degree of achievement or response to the interventions that have been put in place or the degree of progress residents have made towards meeting their identified goals. It usually just repeats the interventions and is task focused not resident focused. This is an area that was identified for improvement in the previous audit and remains open. |
| **Corrective Action:** |
| Ensure evaluations indicate the degree of achievement or response the resident has made towards the stated goals and if interventions are working as expected. |
| **Timeframe (days):**90*(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:**PA Low |
| **Evidence:** |
| Whilst there is documented changes to care planning to show residents changing needs it is not consistently accurate or kept up to date. The cook stated that often she just changes resident’s dietary likes and documents it in the kitchen but does not inform the clinical staff. The use of short term care plans identifies interventions that are put in place for issues such as wound care and some short term medication usage such as eye drops. This area has improved since the previous audit however this remains open as an area identified for improvement. |
| **Finding:** |
| Dietary needs shown in the care plan do not match information found in the kitchen and is not consistent with residents’ immediate needs. Examples include a care plan which identifies the resident is having a nutritional supplement which was stopped two months prior to audit. Two files of the nine reviewed show that assessed falls risk rating does not match what is shown on the care plan. |
| **Corrective Action:** |
| Ensure where progress is different from expected correct information is shown on the residents care plan. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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:** |
| Medicines for residents are received from the pharmacy in Medico Paks monthly or as required. Pharmacy offer same day service. Upon arrival from pharmacy the care manager (RN) checks for accuracy and then a second check is undertaken by the RN who places the medications into the folders. Signing sheet sighted.  The pharmacy is involved in regular medicine reconciliation processes including new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit. Involvement in the annual multidisciplinary meeting is also sighted in resident file reviews.  Medicines are stored in locked medicine trolleys and in the locked treatment room. However not all unused medication has been returned to the pharmacy. This was an area identified for improvement in the previous audit and remains open.   The controlled drugs are stored in a locked cupboard in the nurses’ clinic, two staff sign the register at each administration and a weekly stock count is undertaken. This was an area identified for improvement in the previous audit and is now fully attained. Standing orders are current and meet legislative requirements.  The 14 of 14 medicine charts reviewed show that the GP undertakes at least three monthly medicine reviews. All prescriptions sighted contain the date, medicine name, dose, time of administration, with any allergies. All medicine charts reviewed have each medicine individually prescribed with signing sheets which are fully completed for the administration of medicines.  Whilst the educator stated all staff who administer medicines have completed competencies this could not be verified in documentation sighted as they are not all completed. This is an area which was identified for improvement in the previous audit and remains open.  The RN reports that there are currently no residents who self-administer medicines. The process to assess resident’s competency as per policy is implemented as required. |

##### 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:** |
| All aspects of prescribing, dispensing, review, storage and medicine reconciliation are met. One area identified for improvement from the previous audit related to correct disposal of medication remains open. Three non controlled medications were located in a drawer in medication cupboard on the day of audit. |
| **Finding:** |
| Three expired medicines dated with an expiry of March 2013 were found in the medication cupboard. They were two lots of antibiotics and one container of prednisone. All three lots of medication were prescribed for individual residents. They were discarded and placed in the container to be returned to the pharmacy on the day of audit. |
| **Corrective Action:** |
| Ensure all medicine management systems described in policy and legislation is complied with. |
| **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.

|  |
| --- |
| **Attainment and Risk:**PA Moderate |
| **Evidence:** |
| The medication competency assessment includes oral medications, liquid medication, controlled drugs, warfarin, diabetes medications, eye drops and ear drops. Documentation does not confirm that all staff that require medication competencies have completed them. This was an area identified for improvement in the previous audit and remains open. The review of medication competency records was undertaken alongside the educator/RN.    Four RNs have attended training on the Niki T34 pumps. A further inservice is scheduled for March 2014. |
| **Finding:** |
| A list details the names of 14 staff that are medication competent with assessments reported to have been completed in the last twelve months. A review of records identifies some staff have not completed all components or the records are in-sufficiently detailed. Four medication competency assessments contain the staff members name only and no additional information is completed; some records contain ticks against criteria but are not dated or signed by the person undertaking the competency assessment. |
| **Corrective Action:** |
| Ensure sufficiently detailed documentation is available to verify that all service providers responsible for medicine management have completed all components of the competencies, and can safely administer medications. |
| **Timeframe (days):**90*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.5 (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):***(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### 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:**PA Low |
| **Evidence:** |
| The service has a four week rotating menu, for summer and winter, which is approved by a registered dietitian in January 2013 as suitable for aged care residents. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. Resident food allergies are clearly shown. Two of nine file reviews show registered dietitian input as appropriate.  As identified in criterion 1.3.6.1 the cook does not inform clinical staff of individual residents requested food changes for likes and dislikes and the information in the kitchen is not congruent with that on the dietary profile. This is an area identified for improvement in the previous audit and remains open.   Interviews with six of six residents (three hospital and three rest home) and five of five family/whānau confirm that the food is very nice and that all their needs are met.   All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted have a visible expiry date. Staff have undertaken food safety management education appropriate to service delivery and their certificates are on display.  ARRC 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:**PA Low |
| **Evidence:** |
| Information related to resident’s dietary needs is obtained by the RN during the admission process and the kitchen is informed. The cook confirms during interview that they are able to cater for all additional, modified and special needs. Resident and family/whanau interviews confirm that kitchen staff actively work to ensure all resident’s needs, likes and dislikes are catered for. One area related to up to date dietary profiles identified for improvement in the previous audit is now fully attained. |
| **Finding:** |
| Dietary profile information used to inform care planning is not congruent with information found in the kitchen related to resident food needs, likes and dislikes. |
| **Corrective Action:** |
| Ensure all individual resident nutritional needs are documented in a consistent manner so that all information is congruent. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

|  |
| --- |
| **Attainment and Risk:**FA |
| **Evidence:** |
| Chemicals are sighted as stored securely in locked rooms and are in clearly labelled containers. The area identified as requiring improvement at the last audit now meets the standards. There are material safety sheets present and sighted. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:**FA |
| **Evidence:** |
| The building has a current building warrant of fitness with an expiry date of 22 April 2014. The care manager confirms the ongoing requirements to maintain the building warrant of fitness are maintained. Electrical safety test and tags are present on five pieces of electrical equipment sighted at random during audit. These are identified as requiring improvement at the last audit now meet the standards. Clinical equipment checked including tympanic thermometer, scales and dynamap have current performance monitoring labels.  ARRC contract requirements are met for criteria audited. |

##### 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.)* |

# 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:**FA |
| **Evidence:** |
| The safe and appropriate use of restraints/enablers policy (dated July 2013) includes the definition of enablers which is congruent with the requirements of the standards. This includes an enabler is voluntary and to assist the resident maintain independence. Approved enablers are identified. Five of five caregivers and two RNs interviewed are able to clearly detail the difference between restraints and enablers, the approved enablers and the monitoring requirements when enablers are in use.  Restraints are noted as personal, physical (furniture or equipment) and environmental (placed in an environment to reduce stimulation).  During audit five residents have enablers in use. The use of enablers is documented in the resident file sampled.  Restraint minimisation is included in the inservice programme. Fourteen staff attended the inservice held on 4 March 2013 on restraint minimisation and attendance records sighted. |

##### 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:**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.)* |

# 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:** |
| Infection control data is collected to meet all infection control programme requirements which reflect the Health and Disability Sector Standards. The service collects data monthly and collated information is shared at management and staff meetings as identified in the meeting minutes sighted. The infection control committee, led by the infection control coordinator (RN) evaluates and trends all data and corrective action planning is put in place as required should infection rates increase. The infection control coordinator monitors the effectiveness of the actions to ensure they have assisted in reducing infection rates and reports outcomes monthly to the leadership forum.   All staff members are responsible for the reporting of suspected infections to the infection control coordinator. The infection surveillance data sighted for 2012 (54 infections) with direct comparisons against 2013 (57 infections) identify that infection rates remain stable. An increase was noted in urinary tract infections in January 2014, staff education and an additional fluid round reduced the number from nine in January (2014) to five in February (2014). |

##### 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.

|  |
| --- |
| **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 3.5.7 (HDS(IPC)S.2008:3.5.7)

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

|  |
| --- |
| **Attainment and Risk:**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.)* |