G J & J M Bellaney Limited

Current Status: 22 January 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

Wimbledon Villa currently provides dementia care for up to 27 residents with a current occupancy of 25 residents. [There is a new wing of 18 beds but this was not opened at the time of audit]. The service is managed by is a clinical facility manager who has 30 years of aged care and psychiatric nursing experience. She is supported by an administrative manager, a quality manager and a part time registered nurse. Family feedback during the audit was very positive. An established quality system is in place as well as and implemented staff education programme.

The previous certification identified eight shortfalls around meeting minutes, reporting responsibilities the incident and accident process, senior staff appraisals, resident assessment and care planning, medication management and availability of call bells.

The recent partial provisional audit identified a total of nine shortfalls around; staff education, medication management, transportation of hot food, environmental building work, call bell system for the new wing and emergency water availability. These shortfalls have all been addressed.

Six of eight shortfalls identified at the previous surveillance audit have been addressed. Improvements continue to be required around aspects of medication management and clinical assessment for residents.

This audit has identified further requiring improvement around family information; follow up on quality processes and care plan timeframes.

Audit Summary as at 22 January 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

Indicator	Description	Definition
	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 22 January 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 22 January 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 22 January 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 low risk.

Safe and Appropriate Environment as at 22 January 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 22 January 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 22 January 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 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	G J & J M Bellaney Limited
Certificate name:	G J & J M Bellaney Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit			
Premises audited:	Wimbledon Villa			
Services audited:	Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	22 January 2014	**End date:**	22 January 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:	

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	6
Other Auditors	XXXXX	**Total hours on site**	8	**Total hours off site**	6
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	16	Total audit hours off site	14	Total audit hours	30

Number of residents interviewed		Number of staff interviewed	5	Number of managers interviewed	3
Number of residents' records reviewed	4	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	24	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Friday, 7 March 2014

Executive Summary of Audit

General Overview
Wimbledon Villa currently provides dementia care for up to 27 residents with a current occupancy of 25 residents. [There is a new wing of 18 beds but this was not opened at the time of audit]. The service is managed by is a clinical facility manager who has 30 years of aged care and psychiatric nursing experience. She is supported by an administrative manager, a quality manager and a part time registered nurse. Family feedback during the audit was very positive. An established quality system is in place as well as and implemented staff education programme. The previous certification identified eight shortfalls around meeting minutes, reporting responsibilities the incident and accident process, senior staff appraisals, resident assessment and care planning, medication management and availability of call bells. The recent partial provisional audit identified a total of nine shortfalls around; staff education, medication management, transportation of hot food, environmental building work, call bell system for the new wing and emergency water availability. These shortfalls have all been addressed. Six of eight shortfalls identified at the previous surveillance audit have been addressed. Improvements continue to be required around aspects of medication management and clinical assessment for residents. This audit has identified further requiring improvement around family information; follow up on quality processes and care plan timeframes.

Outcome 1.1: Consumer Rights
There is an open disclosure policy, which describes ways that information is provided to residents and families/representatives at entry to the service continually, and as required, This audit has identified an improvement required around documenting family information and involvement. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints.

Outcome 1.2: Organisational Management
Wimbledon Villa has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. There is an established quality system in place. Quality information reported to monthly staff/quality meetings two weekly management meetings and to the service owner. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. This audit identified an improvement required around follow up and closure of action plans. There are job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertaken external training. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

Outcome 1.3: Continuum of Service Delivery
Assessments, care plans and evaluations are completed by the registered nurse. The previous shortfall around interventions have been addressed. Risk assessment tools and monitoring forms are available. There is an improvement required around the use of pain and behavioural assessments and review of risk assessment tools. Care plans demonstrate service integration and are individualised. There is a requirement to evaluate care plans six monthly. Short-term care plans are in

use for changes in health status. There are three monthly GP reviews. GP medical notes are required to be kept with the resident file. Relatives interviewed are complimentary of the care provided.
The diversional therapist provides an interesting, varied and flexible activity programme for the residents that meets the group and individual recreational needs and abilities of the consumer group. There are 24-hour activity plans in place for individual residents. There is an improvement required around the review of care plans to occur at the same time as clinical care plans.
Medication management policies and procedures are in place. While improvements have been made since previous audit around medication documentation, this audit identified further improvements required around two medication charts.
Meals are prepared on site. The four weekly menu has been reviewed by a dietitian. Individual likes/dislikes and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Hotboxes have been purchased for the delivery of meals to the kitchenette in the new wing.

Outcome 1.4: Safe and Appropriate Environment

There is a current BWOF that expires on 12th September 2014. There is a CPU for the new wing dated 29th November 2013. The home is warm and well ventilated. The service has added a new wing. This wing is not currently opened.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There are currently no residents requiring restraints or enablers. Staff are trained in restraint minimisation and challenging behaviour management.

Outcome 3: Infection Prevention and Control

The infection control coordinator is the clinical facility manager who is a registered nurse. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	6	0	0	0
Criteria	0	40	0	6	0	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	31
Criteria	0	0	0	0	0	0	0	55

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	Five resident files reviewed did not always document family involvement. Fourteen of 26 incident forms did not document that family have been informed of the incident.	Ensure communication with families is documented.	60
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	PA Low	Meetings and actions plans do not always	Ensure that action plans and issues identified as part of	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		improvement in order to meet the specified Standard or requirements is developed and implemented.		document that they have been completed and closed off, and some identified problems have more than one action plan for the same problem.	meeting minute's document that they have been resolved and signed off. Document control should ensure that there is one only action plan for each identified problem.	
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 Low			
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 Low	i) There are no medical notes in the resident file for one resident. ii) There is no pain assessment for one resident with chronic pain and one resident with pain post fall. iii) There is no behavioural assessment for three residents admitted in 2013. iv) Risk assessments have not been reviewed six monthly in three out of five resident files sampled.	i) GP visits are required to be documented in the resident file at the time of visit. ii) Ensure pain assessments are completed for all residents with pain and on prn or regular pain relief. iii) Ensure behavioural assessments are completed on admission. iv) Ensure risk assessments are reviewed at least six monthly or earlier if there are changes to health status.	90
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that	PA Low	Resident files reviewed identified that the individual activity plan is not reviewed at the same	Ensure activity care plans are reviewed at the same time as the clinical care plan.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		are meaningful to the consumer.		time as the clinical care plan.		
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
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 Low	There is a care plan schedule in place, however care plans are not reviewed six monthly.	Ensure care plans are reviewed six monthly or earlier as required	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 Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Two medication charts do not have photo identification. ii) A short course of topical medication does not have a signing sheet.	Ensure all medication charts have photo identification. ii) Ensure signing sheets are in place for topical medications.	30

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: Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Wimbledon provides families with an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the code of rights and information about dementia services. This information is discussed at entry. However, the five resident files reviewed did not always document family involvement. Fourteen of 26 incident forms did not document that family have been informed of the incident. The RN stated on interview that some families and residents do not wish to have this information provided. Interviews with four family members evidences that family feel they are informed The admission agreement covers all the areas for the services contractual requirements. All five resident files reviewed included signed admission agreements on the date of admission. Discussions with three caregivers identified their knowledge around open disclosure. Resident meetings are held by the Diversional therapist. They are not always well documented. The service has noted this and an action plan is in place (December). Resident meetings are documented (link to 1.2.3) Annual resident and relative surveys are also completed. The survey October 2013 documents 83% satisfaction overall. The facility is small enough to ensure staff are known to residents. Staff wear name badges. The service has policies and procedures available for access to DHB interpreter services and family/whānau, are provided with this information in resident information packs. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Four family members stated that they are always informed when their family members health status changes.

D11.3 The information pack is available in large print and advised that this can be read to residents.

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: Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Families interviewed said they are always well informed.
Finding: Five resident files reviewed did not always document family involvement. Fourteen of 26 incident forms did not document that family have been informed of the incident.
Corrective Action: Ensure communication with families is documented.
Timeframe (days): 60 *(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: The service has a complaints policy that describes the management of complaints process. Complaints forms are freely available. Information about complaints is provided on admission. Interview with four family members inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints There is a complaints register that includes all complaints. A review of complaints document that they are followed up with the complainant and discussed with staff, examples include a verbal complaint (June 2013) documented as discussed at the staff meeting in June and follows up in July with the complainant to ensure they were satisfied. Discussions with four family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with three health care assistants stated that concerns/complaints were discussed at monthly staff /quality meetings. D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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: Wimbledon Villa currently provides dementia care for up to 27 residents. There is a new wing of 18 beds but this has not yet opened. At the time of the audit, there were 25 residents. The service is managed by a clinical facility manager who works from Tuesday to Saturday and has 30 years of aged care and psychiatric nursing experience. She also has experience as a manager in aged residential care. She has been a registered nurse at Wimbledon Villa since April 2012 and clinical manager since July 2013. She is supported by an administrative facility manager who has a management and business background and has been a manager at the facility since September 2010, initially as facility manager, and as administrative manager since July 2013. ARC, D17.3di (rest home): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The facility is privately owned and the managers' report frequently to the owner. (ARC D5.1). The organisation has documented values, mission statement and philosophy and these are displayed in the reception area. The information is recorded in the organisation's business plan and admission agreements. The mission statement is 'committed to providing quality residential care in a homely, safe and caring environment giving consideration to the residents' physical, mental, social and spiritual well-being and respecting their dignity'. The current business plan includes goals, specific KPIs for 2013 and 2014, strategic direction including the plan to expand the unit with the new wing.

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:
Wimbledon Villa has an implemented quality framework. There is a documented business and quality plan, including a specific quality plan for the recently completed new wing (not yet in use).

The clinical facility manager is directly involved in operations at the facility with support from a part time RN.
There is a quality coordinator who collects and charts all quality information he also sends monthly reminders of the audits due each month and the results of the previous months audits to the manager.
There is a documented and implemented audit schedule that includes an annual review of audits results for the year. The 2013 audit review documents that previous low scoring audits have improved.
Each month audit results and incidents and accidents data, and infection control are all collated by the quality coordinator and a report is presented to monthly staff and quality meetings, two weekly management meetings and a monthly report to the owner.
A review of monthly meetings and reports documents that audits are consistently reported to meetings and discussed. However meetings and actions plans do not always document that they have been completed and closed off, and some identified problems have more than one action plan for the same problem. This is identified as an area for improvement.

D5.4 The service has policies/ procedures to support service delivery.
D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.
D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.
D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.

Policies and procedures are in place and have been purchased from an external contractor this ensures they are kept up to date and are reviewed. Polices reviewed for this audit all include reference and procedure relevant to dementia level care.
Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually.
Previous finding from the surveillance audit around, reporting of audits to meetings has been addressed. The previous audit also identified that the service did not report all serious incidents to the DHB. There have not been serious incidents since the previous audit. However, the senior staff could describe their responsibility.

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: Each month audit results and incidents and accidents data, and infection control are all collated by the quality coordinator and a report is presented to monthly staff and quality meetings, two weekly management meetings and a monthly report to the owner. Where a problem or issue has been documented, the service completes action plans and present the action plans as part of regular quality and staff meetings. A review of monthly meetings and reports documents that audits are consistently reported to meetings and discussed.
Finding: Meetings and actions plans do not always document that they have been completed and closed off, and some identified problems have more than one action plan for the same problem.
Corrective Action: Ensure that action plans and issues identified as part of meeting minute's document that they have been resolved and signed off. Document control should ensure that there is one only action plan for each identified problem.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA
Evidence: D19.3b; There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the manager and quality manager who monitors issues. 26 incident forms reviewed all document that they have been reviewed and signed by a registered nurse. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Incidents are collated monthly onto a reporting sheet to monitor issues and trends and these are posted up onto the staff room notice board. Monthly data analysis include the comparison against set KPIs for the service, which are also benchmarked against similar services (obtained via the intranet). Annual analysis is also documented and presented to the quality, staff and management meetings. The previous audit identified that where incidents involved two residents, only one form was completed. This audit found that the service completes incident forms for all residents involved in an incident. This was documented with two sets of incidents involving two residents.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is a human resources policy that establishes the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff. Relevant checks are completed to validate individual qualifications and experience. A record of practising certificates is maintained for two registered nurses and other health professionals including the pharmacist, GP's and the dietitian. Wimbledon Villa has in place job descriptions for all positions. A comprehensive in-service education programme is in place. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with staff and a review of documentation demonstrate a commitment to the education of staff that is implemented into practice. D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication competencies. Five of five files reviewed indicate that all staff have a signed contract, orientation, training completed and evidence of recruitment. The registered nurse and the clinical facility manager have a current APC. E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies. E4.5e: Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. Agency staff are very rarely used and only in an emergency. E4.5f: There are 18 caregivers, Twelve have completed the required dementia standards; three, who have been employed for less than a year are in the process of completing the standards and three new staff are yet to start. This is an improvement on the previous partial provisional audit. The previous certification audit found that the Clinical manager appraisal was undertaken by a non-clinical staff member. This audit identified that the RN manager's appraisal had been undertaken by a senior RN.

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: FA
Evidence:
Finding:

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

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

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

Attainment and Risk: 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 1.2.8: 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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff interviewed (three) reported that staffing levels and the skill mix was appropriate and safe. Four family members interviewed stated that they felt there was sufficient staffing. Wimbledon has a set roster both based on two wings which will be staffed separately. The service has staff recruited already for both wings. The new wing has yet to open. The roster and staffing in place for the current residents includes a nominated and trained first aider each shift. There is a full time registered nurse clinical manager Tuesday to Saturday and a registered nurse on the remainder two days. Care giver staffing includes; two full shifts and one half shift for AMs and PMs and two care givers at night. Additional registered nurse/ enrolled nurses are planned for the new wing one for each AM shift plus additional care givers each shift depending on numbers of residents and acuity. The service will commence with one extra care giver each shift.

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: The registered nurse (RN) completes an initial assessment and care plan within 24 hours of admission. The long-term care plan is developed within three weeks of admission in the five resident files sampled. Resident profile and activity assessments are completed in consultation with the family/whanau and resident as appropriate. Family members interviewed state they are involved in their relatives care plan and evaluation. Resident files include a family/whanau/resident representative contact sheet that documents discussions with families such as changes in condition (link 1.1.9.1), GP visits and medication changes. D16.5e: Four of five resident files reviewed identified that the GP had seen the resident within two working days. One resident had been seen by the psychogeriatrican at STAR 1 prior to discharge. A GP was unavailable for interview during the audit. The clinical facility manager (interviewed) stated the residents retain their own GP. The GPs visit three monthly for the three monthly review and are available for resident visits as required. All residents have a support links needs assessment approval for dementia level of care. The community psychiatric nurse visits regularly, follows up residents under the older adult mental health service and visits residents of concern. The service is readily available for advice by phone. A range of assessment tools completed available for use include (but not limited to); a) coombes falls risk assessment and mobility guide, b) Braden pressure area risk assessment , c) continence assessment (and three day bladder diary), d) cultural assessment, e) Robinsons acuity assessment, f) admission and food information and menu card, g) abbey pain assessment, and h) behaviour assessment. The previous surveillance audit evidenced that assessments were not always in place, this remains a shortfall (link 1.3.6.1).

Staff could describe a verbal handover at the beginning of each duty and a communication book that maintains a continuity of service delivery. Four resident files identified integration of allied health and a team approach. One resident file did not contain any medical notes from GP visits (link 1.3.6.1).

Tracer methodology

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

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

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

Attainment and Risk: 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:
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 Low
Evidence: Relatives interviewed state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. The clinical facility manager verified families are informed of any changes to their relative's health and interventions required to meet the resident's needs (link 1.1.9.1). The care plan includes; communication, mobility, continence, ADLs, skin integrity, dietary information, social, spiritual, cultural and behaviours. D18.3 and 4 Dressing supplies are available. There is a comprehensive wound management assessment, plan and evaluation document. There are no pressure areas. There is one surgical wound with a wound assessment, plan and evaluations completed. A short-term care plan is in place for the surgical wound. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. A three-day bladder diary is completed and the information used to develop the care plan regarding elimination. Specialist continence advice is available as needed and this could be described by the clinical facility manager interviewed. Residents are weighed monthly and weight gain/loss is monitored with more frequent weights. An alternative weight measure of upper arm circumference is used if necessary. Admission food and fluid information is completed with a copy to the kitchen. Individual menu cards are available for staff to ensure resident dietary needs are met. The GP is notified of any resident weight loss. Supplementary drinks, high calorie diet and nutritious snacks are offered. The dietitian is involved if necessary. Coombes falls risks assessments are carried out on admission. Staff report all falls on accident/incident forms. A post falls investigation is carried out and corrective actions evidenced in the long-term care plan. A repeat falls analysis is completed for frequent fallers to identify falls prevention strategies. Behaviour management is documented in the long-term care plan with described behaviour strategies and interventions. Behaviour charts are in place for residents exhibiting increased disturbing behaviour. Detailed management plans describe past behaviours and early warning signs and symptoms. The community psychiatrist visits the service regularly and liaises closely with the older adult mental health service for any resident concerns.

A range of assessment tools completed available for use include (but not limited to); a) coombes falls risk assessment and mobility guide, b) Braden pressure area risk assessment , c) continence assessment (and three day bladder diary), d) cultural assessment, e) Robinsons acuity assessment, f) admission and food information and menu card, g) abbey pain assessment, and h) behaviour assessment. There is an improvement required around the review of risk assessments, pain assessments and behaviour assessments on admission This remains a shortfall from the previous audit.

The GP is available to visit residents of concern or changes to health status as assessed by the RN. GP visits are required to be documented in the resident file at the time of visit. There are no medical notes in the resident file for one resident.
Previous surveillance audit findings around documentation of care plan interventions have been addressed.

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 Low
Evidence: The GP is available to visit residents of concern or changes to health status as assessed by the RN. Abbey pain assessments are completed for three residents who identify pain. Behaviour management is documented in the long-term care plan with described behaviour strategies and interventions. Behaviour charts are in place for residents exhibiting increased disturbing behaviour.
Finding: i) There are no medical notes in the resident file for one resident. ii) There is no pain assessment for one resident with chronic pain and one resident with pain post fall. iii) There is no behavioural assessment for three residents admitted in 2013. iv) Risk assessments have not been reviewed six monthly in three out of five resident files sampled.
Corrective Action: i) GP visits are required to be documented in the resident file at the time of visit. ii) Ensure pain assessments are completed for all residents with pain and on prn or regular pain relief. iii) Ensure behavioural assessments are completed on admission. iv) Ensure risk assessments are reviewed at least six monthly or earlier if there are changes to health status.
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: PA Low
Evidence: The activities person currently implementing the activity programme is a qualified diversional therapist (DT) and has previous experience working in the disability sector and has completed the dementia care course. The DT is a member of the local DT peer support group and attends training as offered. The DT has been in the role for one month and is employed for seven hours a day Monday to Friday. Caregivers assist with the implementation of the programme over the seven-day week. The

programme is planned a month in advance. Daily activities are written up on notice board. Planned activities are flexible and include (but not limited to); news and views, exercise, board games, floor bowls, baking/cooking, garden walks, ball fun, flower arranging, arts and crafts, poetry, happy hours, movies and sing-alongs. One on one quality time with residents include discussions, reminiscing, walks, manicures and other activities that meet the individual recreational needs. There is a main lounge for group activities/entertainment and a quieter lounge where smaller or individual activities can take place. Community visitors include pet therapy visits, variety of entertainers, Senior club, school children and associates of Massey university visit. Residents have access to spiritual visitors. Two residents attend church with their family members. One Maori resident attends Marae based functions with their family. Residents are involved in the care of the home budgies and cats. The service has a van and there are regular van drives and outings/picnics. The DT and caregiver (with First Aid certificate) supervise residents on outings. A resident profile and cultural assessment is completed on admission of a new resident. An attendance register and progress notes are maintained. The activity care plan is individualised and covers activities that may be provided for the resident over a 24 hour period.
D16.5d Resident files reviewed identified that the individual activity plan is not reviewed at the same time as the clinical care plan.

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: PA Low
Evidence: The activity care plan is individualised and covers activities that may be provided for the resident over a 24 hour period. The activity plan also includes alternative activities that may be successful in the de-escalation of disturbing behaviours.
Finding: Resident files reviewed identified that the individual activity plan is not reviewed at the same time as the clinical care plan.
Corrective Action: Ensure activity care plans are reviewed at the same time as the clinical care plan.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.8: 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 Low
Evidence: Long term care plans are reviewed and evaluated by the registered nurse. A care plan review schedule in place however care plan reviews are not reviewed at least six monthly. The Multidisciplinary team (MDT) is involved in the review the care plans and includes the clinical nurse manager, RN, diversional therapist, care assistants and GP. The family/whanau/resident representative is involved in the care plan review. There is at least a three monthly review by the medical practitioner. There are short term care plans for acute and short-term needs. Short term care plans are reviewed regularly with on-going problems included into the long term care plan. Examples of short term care plans in use included; shortness of breath, fall, wound and weight loss (resolved). D16.4a Three of four long term care plans have not been evaluated at least six monthly, one care plan is not due for review.

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

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 Low
Evidence: Long term care plans are reviewed and evaluated by the registered nurse. The Multidisciplinary team (MDT) is involved in the review the care plans and includes the clinical nurse manager, RN, diversional therapist, care assistants and GP. The family/whanau/resident representative is involved in the care plan review.
Finding: There is a care plan schedule in place, however care plans are not reviewed six monthly.
Corrective Action: Ensure care plans are reviewed six monthly or earlier as required
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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 Low
Evidence: Medications are stored in a locked medication room. There is a controlled drug safe. Currently there are no residents on controlled drugs. There is a history of weekly controlled drug checks in the controlled drug register. The supplying pharmacy deliver all pharmaceuticals. The RN maintains a returned to pharmacy log. The RN checks the four weekly medication packs and completes a blister pack verification form. Any discrepancies are fed back to the supplying pharmacy. After hours prescriptions are supplied by the after hour's pharmacy. RN's and senior caregivers who have completed medication competency administer medications. Caregivers who check out controlled drugs complete a controlled drug competency assessment. Staff have completed annual medication competencies and attended medication education provided by the medico representative in June 2013. Each GP has a signed standing order of non-prescribed pre-approved medications for their residents. There are no self-medicating residents. The administration of midday medications observed is compliant with medication administration practice. All eye drops are dated on opening. The medication fridge is monitored daily. There are no gaps on the signing sheets of 10 medication signing sheets sampled. There are respite/short term medication sign off forms in place. Ten medication charts sampled are reviewed by the GP three monthly and all had allergies/sensitivities noted as applicable. This audit identifies improvements around photo identification, and signing sheet for prescribed topical medication. Previous surveillance shortfalls around signing of charts remains an improvement to be addressed by the service. Previous shortfalls identified at the partial provisional audit around; documentation of allergies, PRN medication, three monthly GP reviews, have all been addressed.

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: Eight of ten medication charts include photo identification. Eight of ten include GP signatures for all medications prescribed and discontinued. All medication charts have been reviewed by the GP three monthly and this is an improvement on previous audit.
Finding: Two medication charts do not have photo identification. ii) A short course of topical medication does not have a signing sheet.
Corrective Action: Ensure all medication charts have photo identification. ii) Ensure signing sheets are in place for topical medications.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)
Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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: FA
Evidence: The service employs a full time qualified chef and part time cook. There is a four weekly menu in place that has been reviewed by a dietitian. All meals and baking is prepared and cooked on site. The main meal is at midday. A daily menu board is in the dining room. Staff are observed sitting with residents and assisting with meals as required at the midday meal. The chef is notified of resident's dietary requirements, likes and dislikes on admission. The RN informs the chef of any dietary changes required or weight loss concerns. The chef has a resident information folder in the kitchen. Complan and adequate fluids are offered regularly. Normal and moulied foods are currently provided. Alternative foods are available. Additional nutritious snacks such as sandwiches, fruit platters, biscuits, yoghurts, cheese and desserts are sighted in the fridge. All foods are date labelled. The fridge and freezer is temperature monitored daily. Recordings of daily hot food monitoring is sighted. The kitchen is well equipped with stove tops, fan bake ovens, microwave and new sanitizer. There is adequate storage and pantry space. Dry goods are sealed, dated and labelled. There is a latched half door barrier between the kitchen and dining room. A kitchen duties list is sighted. Staff are observed wearing appropriate protective wear in the kitchen. Staff have attended food safety and hygiene education. Hot boxes have been purchased for the transport of plated meals to the kitchenette for the residents in the new wing when it opens. The new kitchenette has been completed.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: There is a current BWOF that expires on 12th September 2014. There is a CPU for the new wing dated 29th November 2013. The home is warm and well ventilated. The service has added a new wing. This wing is not currently opened. The previous partial provisional audit evidenced that window coverings were yet to be in place, furniture had yet to be installed, and the unit was not yet secure, hot water temperature monitoring had not commenced and a CPU was not yet in place. All these environmental shortfalls have been addressed for the new unit.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: The previous partial provisional audit evidenced that fixtures and fittings were not in place for bathrooms in the new wing. Visual inspection identified that all bathrooms are now fully fitted and operational.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The previous partial provisional audit identified that the laundry did not have enough capacity for the additional residents, and that there was not enough folding space for linen. Visual inspection at this audit identified that the new wing has a designated folding area. Staff meetings (June 2013) document that staff have discussed the process for laundry in the existing laundry. The outcome is that given that only personal laundry is undertaken on site (Hotel linen is contracted out), there is enough capacity in the laundry to accommodate 18 further residents.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: The previous surveillance audit identified that the lounge has no call bell and the previous partial provisional audit required a call bell system in the new wing. Visual inspection identified that the service has installed a new call bell system, which includes a call bell in all lounges and all areas in the new wing. The previous shortfall around insufficient stored water has been addressed by the service. There is 1900 litres stored on site. The NZ Fire Service approved the evacuation scheme to include the new Rose wing on 18 October 2013.

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

Where required by legislation there is an approved evacuation plan.

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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: There is a restraint policy There is a restraint manual applicable to the type and size of the service. The policies include management of challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly, challenging behaviour training has been provided. The policies and procedures are comprehensive, included definitions, processes and use of enablers. The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and no restraints.

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 monitoring is the responsibility of the RN manager. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Wimbledon Villa are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff/quality meetings, two weekly management meetings and are reported to the owner monthly. The infection control coordinator in association with the quality manager uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Internal audit of infection control is included in the annual programme and occurs monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. There is evidence of GP involvement and laboratory reporting. A recent outbreak is reported in the staff meeting (June2013) and included discussion and education.

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.)*