

Elms Court Rest Home Limited

Current Status: 18 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

Elms Court rest home provides rest home level care services for up to 15 residents. On the day of the audit there were 14 rest home residents. Elms Court has an owner/manager and an assistant owner/manager. They are supported by a registered nurse and care staff. There continues to be an implemented quality and risk management system in place that is monitored and this generates improvements in practice and service delivery.

The service has addressed five of seven shortfalls from the previous certification audit around: collation of results of resident and family survey; employment reference checks; the education plan; soft diet meals; and safe chemical handling training.

Further improvements continue to be required around completing aspects of care planning and providing education for new infection control coordinator.

This surveillance audit identified additional shortfalls around documented position descriptions for all staff, ensuring care plans include all care requirements, aspects of medication management and infection control education for staff.

Audit Summary as at 18 February 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 18 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 18 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 18 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 18 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 18 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 18 February 2014

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

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:	Elms Court Rest Home Limited		
Certificate name:	Elms Court Rest Home Limited		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Elms Court Rest Home		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 18 February 2014	End date: 18 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:			14

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	5
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	8	Total audit hours off site	6	Total audit hours	14
Number of residents interviewed	5	Number of staff interviewed	4	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	3	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	8	Number of relatives interviewed	2
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 Tuesday, 18 March 2014

Executive Summary of Audit

General Overview

Elms Court rest home provides rest home level care services for up to 15 residents. On the day of the audit there were 14 rest home residents. Elms Court has an owner/manager and an assistant owner/manager. They are supported by a registered nurse and care staff. There continues to be an implemented quality and risk management system in place that is monitored and this generates improvements in practice and service delivery. The service has addressed five of seven shortfalls from the previous certification audit around: collation of results of resident and family survey; employment reference checks; the education plan; soft diet meals; and safe chemical handling training. Further improvements continue to be required around completing aspects of care planning and providing education for new infection control coordinator. This surveillance audit identified additional shortfalls around documented position descriptions for all staff, ensuring care plans include all care requirements, aspects of medication management and infection control education for staff.

Outcome 1.1: Consumer Rights

Open disclosure is inherent in the day-to-day operations of the service. Families report that they are always informed when their family member's health status changes or of any other issues or adverse events arising. Complaints processes are implemented. Complaints and concerns are actively managed.

Outcome 1.2: Organisational Management

Elms Court has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to the management and staff meeting. The service is active in analysing data with corrective actions identified and implemented. The service has made improvements in this area. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. The service has addressed and monitored previous findings relating to implementing action plan following resident surveys. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The service has addressed and monitored previous shortfalls relating to staff files and employment practices, and maintaining education records. Further improvement is required relating to provision of a job descriptions for the registered nurse. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Outcome 1.3: Continuum of Service Delivery

Elms Court has implemented systems that evidence each stage of service provision is developed with resident and/or family input, and is coordinated to promote continuity of service delivery. Improvement is required relating to ensuring time frames for completed documentation are adhered to. Residents and family interviewed confirm their input into care planning and care plan evaluations. Improvements are required whereby all interventions required are noted in the care plans and are consistent with meeting residents' needs. Evaluations of care plans are reviewed more frequently if a resident's condition changes. Where progress is different from expected, the service responds by

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	A position description is not available for the registered nurse role.	Ensure that all employees have a detailed position description at commencement of employment.	60
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Four of five long term care plans are current, however, two care plans were evaluated outside the six month time frame – seven and nine months respectively.	Ensure that all aspects of care planning, including evaluations, are conducted within the required time frames.	60
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	PA Low	One of five resident files reviewed evidence that not all care requirements are recorded in the long term care plan. The	Ensure all care plans record the level of support required to meet the resident's assessed needs and desired outcomes.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		needs, and desired outcomes.		momentum care plan does not record identified interventions relating to self-medication, mobility, and asthma management.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	On review of the controlled drug register it was noted that the count was incorrect. A new supply had been delivered from pharmacy the night before but had not been entered in to the register. The medication was stored in the safe. Advised that the registered nurse enters the amount when she attends the service the next day; b) the time that the controlled drug is recorded as checked out for administration does not align with administration time. Current practice is that when two staff are on duty, the medication is checked and recorded as out – however, the medication is not administered until a later time. The medication remains in the controlled	Ensure that controlled drugs are entered and recorded in the controlled drug register when delivered from pharmacy; and b) ensure that controlled drugs are observed to be administered to the resident by two staff members at the time stated on the medication order.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				drug cupboard until administered.		
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 Low	The registered nurse is responsible for assessing caregivers on medication administration competency and administers medications when on duty. She has not completed a medication competency.	Ensure the registered nurse has completed an annual medication competency.	60
HDS(C)S.2008	Criterion 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.	PA Low	A recently admitted resident's GP has typed out a list of medications for the new resident and signed and dated the bottom of the sheet. It is not clear which medications are regular or PRN and medication orders are not signed for individually.	Ensure all residents have an individual medication chart which clearly describes the medications prescribed, dosage, is signed and date for each individual order, clearly states the time of administration and uses, for and non-regular items.	60
HDS(IPC)S.2008	Standard 3.2: Implementing the infection control programme	There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	PA Low			
HDS(IPC)S.2008	Criterion 3.2.1	The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.	PA Low	The infection control coordinator (registered nurse) has been in the role of IC coordinator since commencing employment in January 2014 and has yet to attend infection control education; b) staff in-service relating to infection prevention and	Registered nurse to attend infection control education and b) staff to be provided with in-service relating to infection prevention and control.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				control not provided in past two years.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an open disclosure policy, a complaints policy and an incident/accident reporting policy.
Five residents and two family members report they were welcomed on entry and were given time and explanation about the services and procedures. The owner/manager is readily accessible, confirmed in interviews with two caregivers, five residents and two family.
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 Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.
D16.4b The two family members interviewed state that they are always informed when their family member's health status changes or of any other issues arising.
Evidence of open disclosure to the resident and relatives was verified in all accident/incident forms reviewed and in progress notes in five of five files reviewed. A family contact form in each resident file also records when families are contacted – following incidents, GP visits and medication changes.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. Five residents and two relatives confirm they are aware of the complaints process and they would feel comfortable lodging a complaint or discussing concerns with the manager if necessary.</p> <p>There is a complaints register. There have been no complaints received in 2012, 2013 or to date in 2014. Advised that all documentation for complaints and feedback including acknowledgement letters, investigation reports and follow up letters would be maintained in the complaints folder.</p>

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

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

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

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

Outcome 1.2: 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: Elms Court rest home is a family owned and operated facility. The service is managed by an experienced owner/manager and an owner/assistant manager. The family have owned the facility for over 20 years. Elms Court provides rest home level care and support for up to 15 residents; on the day of audit there were 14 permanent residents and no respite residents. There is a business plan 2012-2014 which is reviewed at management meetings. The service employs the services of a residential aged care consultant who provides support to the owners and provides policy and procedure updates. The business plan has the key objectives which guide to business and relate to resident care, financial

management, promoting resident independence, and encouraging residents to maintain community activities. There is a facility quality plan 2013-2014, and a quality planner. There are documented indicators and targets. The mission statement for Elms Court states: "our aim is to provide a flexible extended family environment which recognises the individuality of each person".

The owner/manager attends more than eight hours annually of professional development relating to the management of an aged care environment. She has recently attended a course relating to older person mental health and has attended management training in the past two years.

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: FA

Evidence:

The service has a quality assurance and risk management programme which is designed to monitor contractual and standards compliance and the quality of service delivery. There is a strategic plan for 2012 - 2014 and a current quality and risk management plan. Quality goals include client focused services, high standard of services, orientation for all new staff, education for staff, a homely atmosphere for staff, promoting safe resident independence, involvement of family, and efficient use of resources. The bi-monthly management meetings reflect the service's commitment to continuous quality improvement. There is an internal audit schedule in place. There is evidence of the regular monitoring of a wide variety of aspects of the service via this internal audit schedule, the education planner and meeting planner. Feedback and progress relating to quality and risk management systems is provided during staff meetings and bi-monthly management meetings. The management meeting includes (but is not limited to) feedback pertaining to: internal audits; quality initiatives; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; education. Minutes are maintained and easily available to staff in the nurses room (minutes sighted for December 2013). Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Ems Court's commitment to on-going quality improvement. Discussions with one registered nurse and two caregivers confirm their involvement in the quality programme. Resident/relative meetings take place at random intervals – next scheduled for March 2014. Discussion is held around activities, meals, outings, health and safety and laundry. Due to the small size of the service, residents are able to discuss any issues or matters of concern with management on a daily basis.

D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. The reviews of the policies and procedures are scheduled to be completed on bi-annual basis and is discussed at management meetings. Updates are provided by a contracted aged care consultant.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety is discussed at management meetings and includes hazard management, falls and incidents, and hazard identification.

There is a comprehensive infection control manual. There is a restraint policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.

A document control system is in place. Documents no longer relevant to the service are removed and archived. Policies and procedures that are updated are documented on a document control sheet that is held in the front of each policy manual. The manager reports staff are made aware of policy updates via staff meetings and copies of policy updates are posted in the nurse's station. Staff sign to acknowledge that they have read any new or updated policies.

The service collects information on resident incidents and accidents, and staff incidents/accidents. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by the owner/manager. The registered nurse completes any additional follow up and collates and analyses data to identify trends.

Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through resident/relative meetings and surveys are followed up and actioned.

Infection control data is collated monthly and reported to staff. One registered nurse and two care givers interviewed are well informed about infection control.

Actual and potential risks are identified and corrective actions initiated. There is a hazard register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually.

Restraint/enabler use is reviewed and reported at the bi-monthly management meeting and three monthly staff meetings. Results of internal audits, reports from incidents and accidents, infection rates, restraint use and health and safety issues are discussed with staff through the three monthly staff meetings. This meeting incorporates discussion around health and safety, resident issues, infection control, education and quality assurance. Staff are able to contribute to the staff meeting agenda. A handover folder also records infections and resident issues.

A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually. Internal audits are completed and include the identification of any issues and corrective actions where required. Internal audits conducted for 2013 include health and safety, kitchen, laundry, cleaning, privacy, care plans and medication. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored. Two yearly resident satisfaction surveys are conducted (last conducted April 2012). The survey attracted a low return rate however, residents interviewed agreed that they were happy with the overall quality of the service. The service has addressed and monitored this previous improvement from last audit.

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: 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:

Discussions with the owner/manager and registered nurse confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications. D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents.

The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident by the individual witnessing the event, with immediate action noted by the care staff on duty. The registered nurse follows up on any clinical issues or care staff instigate referral to the general practitioner or emergency services if required. Advised by the registered nurse, who has been employed at the service since the beginning of the year, that there have been no falls or incidence in this time. A review of the incident folder evidences five incidents in November 2013, two in December and none in January 2014. Two residents who had previously had one fall each in December 2013

and two falls and two skin tears in November 2013, have had no falls in January or February 2014. The registered nurse advised that she was able to identify the reasons for falls (constipation) and has made improvements to the residents care and falls prevention measures are in place. The owner/manager signs off on all adverse events. Minutes of the staff meetings reflect a discussion of incidents/accidents and actions taken. Accident and incident forms, and records in the medical and progress notes provide evidence that families are kept informed - and confirmed on family interviews.

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

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Elms Court employs eight permanent staff. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity.

A copy of practising certificates including registered nurses and general practitioners is kept. Current practising certificates were sighted for all registered health professionals - registered nurses and general practitioner. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Three staff files were reviewed (one registered nurse and two caregivers). Reference checks are completed before employment is offered and are evident in one recent employee file reviewed (registered nurse). Signed employment contracts are held on file. The service has addressed and monitored this previous finding. Position descriptions are evident in the two caregiver files reviewed. A position description is not available for the registered nurse. Improvements are required in this area. Police vetting is not routinely conducted.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers were able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the owner/ manager for staff who require additional training. Orientation programmes are specific to the service type (e.g., RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all three staff files audited).

Discussion with the owner/manager, one registered nurse, and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is completed education plan for 2013 with records maintained for content and attendance. The annual training programme exceeds eight hours annually. Additionally, all caregivers are required to undertake aged care education within six months of commencement of employment. Two caregivers interviewed have both completed the National Certificate in care of the elderly.

Education in 2013 included (but not limited to): cultural safety and spirituality, COPD and asthma, restraint, documentation, wound care, challenging behaviours, and medication management. Infection control education has not been provided in the past two years (link #3.2.1). Continence management and sexuality and intimacy were covered in 2012. The service has made improvements in this area.

Medication education and competencies completed in 2013 for all care staff. The registered nurse has not completed a medication competency (link #1.3.12.3). All care staff have completed first aid training. Education sessions are combined with staff meetings to ensure maximum staff attendance. Education records are maintained and are up to date. The owner/manager maintains comprehensive staff records to identify training needs and attendance. This is an improvement from the previous audit.

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:

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Three staff files were reviewed (one registered nurse and two caregivers). Reference checks are completed before employment is offered and are evident in one recent employee file reviewed (registered nurse). Signed employment contracts are held on file. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers were able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the owner/ manager for staff who require additional training. Orientation programmes are specific to the service type (e.g., RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all three staff files audited). Position descriptions are evident in the two care giver files reviewed. A position description is not available for the registered nurse who has been the role for six weeks.

Finding:

A position description is not available for the registered nurse role.

Corrective Action:

Ensure that all employees have a detailed position description at commencement of employment.

Timeframe (days): 60 (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: <p>There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Interviews with one registered nurse, two caregivers, five residents and two family members identify that staffing is adequate to meet the needs of residents. The owner/manager works full-time Monday-Friday and shares the after-hours on-call with the registered nurse. The registered nurse works eight hours per week – four hours each on Tuesdays and Thursdays. The roster includes the at least one care giver on duty on each shift with owner/manager assisting with cares Monday to Friday and another care giver from 8-1pm on Saturday and Sunday. Caregiving staff attend to resident’s laundry and cleaning. The kitchen is staffed by the owner/manager and care staff. The owner/manager reports staff numbers are adjusted based on resident acuity and the occupancy rate.</p>

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

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

Attainment and Risk: FA
Evidence:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.3: 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: PA Low
<p>Evidence:</p> <p>The registered nurse has been employed for the past six weeks and is responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission as evidenced in one new resident file reviewed. The nursing care assessments and long term care plans are to be completed within three weeks and align with the service delivery policy. Five files were reviewed with four of five long term care plans completed are within the three week time frame and appropriate assessments have been completed for all identified issues. The service has made improvements in this area. Advised that the RN attends the facility two days per week. The service has taken steps to ensure that any new admissions are conducted on the days that she works or the previous day to ensure that time frames for admission documentation are adhered to. Improvements are required whereby care plan evaluations are conducted within specified time frames.</p> <p>Wound care assessments and treatment plans were reviewed and included one resident with an infected wound which was been dressed at the local medical centre. Short term care plans have been developed for wound management, infections, skin tears, behaviours and pain. A diversional therapy plan is used for activities with an activities assessments, client profile, activities records and six monthly evaluations completed by the activities coordinator and care staff.</p> <p>The registered nurse and owner/manager are familiar with the timeframes and files reviewed were kept up to date. InterRAI assessment tool has been used by the previous registered nurse and is evident in two resident files reviewed. The registered nurse advised that she is booked in to attend InterRAI training in 2014. D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours for one new admission. A long term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months for two of five care plans reviewed. D16.5e; Medical assessments were documented in five of five long term files reviewed within two working days of admission. Three monthly medical reviews were documented in all five files by a general practitioner. It was noted in all five resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly. On interview the GP advised that residents are seen three monthly or more frequently if required. More frequent medical assessment/ review noted occurring in residents with acute conditions.</p> <p>Assessment tools available (other than interRAI) for completion on admission include a) pressure area risk assessment, b) pain assessment and pain charts, c) challenging behaviours and monitoring forms, d) continence assessment, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to</p>

condition or at least six monthly.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. On interview, the GP (with majority of residents) advised that he visits the service weekly or residents attend his practice. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Five files reviewed evidence this is occurring. The GP interviewed also stated that the service is prompt at informing of changes in the residents conditions and that instructions are carried out.

Tracer Methodology: Rest home resident.

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: PA Low

Evidence:

The registered nurse is responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission as evidenced in one new resident file reviewed. The nursing care assessments and long term care plans are to be completed within three weeks and align with the service delivery policy. Five files were reviewed with four of five long term care plans completed within the three week time frame and appropriate assessments have been completed for all identified issues. Advised that the RN attends the facility two days per week. The service has taken steps to ensure that any new admissions are conducted on the days that she works or the previous day to ensure that time frames for admission documentation are adhered to. Care plan evaluations have been completed within six months for two of five care plans reviewed (one new admission).

Finding:
Four of five long term care plans are current, however, two care plans were evaluated outside the six month time frame – seven and nine months respectively.
Corrective Action:
Ensure that all aspects of care planning, including evaluations, are conducted within the required time frames.
Timeframe (days): 60 (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:
Five resident files were reviewed: Care plans are individualised and personalised to reflect needs, goals and outcomes in the long term care plan in three of five files reviewed – one recent admission, and one file which did not capture all identified care requirements. Each aspect of the long term care plan includes a goal, interventions and evaluations. One resident has a momentum care plan which relates specifically to the CAP's as identified from the interRAI assessment. Not all interventions are recorded to meet the identified needs. Improvements are required in this area. Of the five files reviewed, four of these residents were interviewed and all four reported their needs were being appropriately met. Three residents with long term care plans have all care issues recorded under headings relating to personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture, medication, controlling pain, sleeping patterns/rest, intimacy/sexuality, communication, memory loss/confusion, challenging behaviour. Care plans were current and interventions reflect the assessments conducted and the identified requirements of the residents in three of five files reviewed – one does not, and one new resident has yet to have a long term care plan developed. Interview with one registered nurse and one owner/manager verified involvement of families in the care planning process. There were short term care plans in four of five files reviewed and include plans for infections, wounds, skin tears, pain

management, changes in health status, pain and behaviour management. One resident with a wound demonstrate a link between short term care planning and wound management plans – these are completed at the local medical practice.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

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:

Care plans are individualised and personalised to reflect needs, goals and outcomes in the long term care plan in three of five files reviewed – one recent admission, and one file which did not capture all identified care requirements. Each aspect of the facility's long term care plan includes a goal, interventions and evaluations. One resident has a momentum care plan which relates specifically to the CAP's as identified from the interRAI assessment. Not all interventions are recorded to meet the identified needs. Of the five files reviewed, four of these residents were interviewed and all four reported their needs were being appropriately met. Three residents with long term care plans have all care issues recorded under headings relating to personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture, medication, controlling pain, sleeping patterns/rest, intimacy/sexuality, communication, memory loss/confusion, challenging behaviour. Care plans were current and interventions reflect the assessments conducted and the identified requirements of the residents in three of five files reviewed – one does not, and one new resident has yet to have a long term care plan developed.

Finding:

One of five resident files reviewed evidence that not all care requirements are recorded in the long term care plan. The momentum care plan does not record identified interventions relating to self-medication, mobility, and asthma management.

Corrective Action:

Ensure all care plans record the level of support required to meet the resident's assessed needs and desired outcomes.

Timeframe (days): 60 (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:

There is an activities coordinator who works for 14 hours a week. Care staff also provide activities at other times. The programme is planned monthly and residents have input in to what activities are provided. Individual and group activities are catered for. Activities planned for the day are discussed with the residents.

A resident profile and activities assessment is completed on admission which forms the basis for the diversional therapy plan. The plan includes goals and ambitions as well as a plan of meaningful activities. The resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities documentation. The programme is evaluated and can be individually tailored according to resident's needs.

The owner/manager and registered nurse advised that residents are able to participate in community activities as well as activities in the service itself.

Activities include (but not limited to): outings, exercises, walking bus, gardening, housie, happy hour, seasonal celebrations, crafts, painting, knitting, individual one to one time, attending church services, and assisting with house hold chores. Residents were observed participating in bbq. Resident meetings are held at random intervals as feedback relating to activities, meals and laundry is gathered on a daily basis.

Five residents and two family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Four of five care plans reviewed evidenced that the entire care plan evaluations are comprehensive, relate to each aspect of the long term care plan and record the degree of achievement of goals and interventions. Care plans reviewed are updated as changes are noted in care requirements. Short term care plans are well utilised for residents. Any changes to the long term care plan are dated and signed. Four of five care plans reviewed included handwritten updates to the plan as needs have changed for certain aspects of the plan (one recent admission).

Short term care plans were sighted for wounds, infections, pain management, and short term health issues.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated with exceptions (link #1.3.3.3).

D16.3c: All initial care plans were developed with 24 hours of admission and 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: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the registered nurse. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications with the exception of one recent admission. A care giver was

observed administering medications to the residents at a lunch time medication round and followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in the locked treatment room/nurses station. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. No evidence of transcribing on 14 of 14 medication administration signing sheets or on five of five care plans reviewed.

Controlled drugs are stored in one locked safe and cupboard inside the locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. One resident is using controlled drugs. However, on review of the controlled drug register it was noted that the count was incorrect. A new supply had been delivered from pharmacy the night before but had not been entered in to the register. It was stored in the safe. Advised that the service registered nurse enters the amount when she attends the service the next day. Also noted is the time that the controlled drug is recorded as checked out for administration? Current practice is that when two staff are on duty, the medication is checked and recorded as out – however, the medication is not administered until a later time. The medication remains in the controlled drug cupboard until administered. Improvements are required in this area. Controlled drugs are checked weekly and stock take is conducted six monthly. Medication fridge's are monitored daily and recorded weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies (or nil known allergies) are recorded on all 14 drug charts reviewed. An annual medication administration competency is completed by the registered nurse for care givers. The registered nurse has not completed a medication competency. Improvement is required in this area.

There is a self-medicating resident's policy in place. A self-medication assessment checklist is available. There is currently one resident who self-administers medications. The registered nurse provides her with a weekly supply of pre-packed medications. Appropriate assessment and verification by the registered nurse and GP has been completed and reviewed (last conducted 11 December 2013). Documentation and care planning around the resident self-medicating requires improvement (link #1.3.6). The resident has a locked drawer in her room where medications are stored. Staff check to ensure that this is taken.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements with the exception of one new admission. The GP has typed out a list of medications and signed the bottom of the sheet. It is not clear which medications are regular or PRN and medication orders are not signed for individually. Improvements are required in this area. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. As required medication orders (PRN) all record indications for use.

D16.5.e.i.2; Thirteen of fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: PA Moderate

Evidence:

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the registered nurse. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications with the exception of one recent admission. A care giver was observed administering medications to the residents at a lunch time medication round and followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in the locked treatment room/nurses station. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. No evidence of transcribing on 14 of 14 medication administration signing sheets or on five of five care plans reviewed. Controlled drugs are stored in one locked safe and cupboard inside the locked treatment room/nurses station. Controlled drugs are recorded and checked by two staff members in the controlled drug register. One resident is prescribed controlled drug medication. Controlled drugs are checked weekly and stock take is conducted six monthly. Medication fridge's are monitored daily and recorded weekly.

Finding:

On review of the controlled drug register it was noted that the count was incorrect. A new supply had been delivered from pharmacy the night before but had not been entered in to the register. The medication was stored in the safe. Advised that the registered nurse enters the amount when she attends the service the next day; b) the time that the controlled drug is recorded as checked out for administration does not align with administration time. Current practice is that when two staff are on duty, the medication is checked and recorded as out – however, the medication is not administered until a later time. The medication remains in the controlled drug cupboard until administered.

Corrective Action:

Ensure that controlled drugs are entered and recorded in the controlled drug register when delivered from pharmacy; and b) ensure that controlled drugs are observed to be administered to the resident by two staff members at the time stated on the medication order.

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: PA Low

Evidence:

An annual medication administration competency is completed by the registered nurse for care givers – evidenced in staff files reviewed. The owner/manager maintains a list of staff and when competencies are due to be reviewed. Medication management education has been provided in February 2013.

Finding:

The registered nurse is responsible for assessing caregivers on medication administration competency and administers medications when on duty. She has not completed a medication competency.

Corrective Action:

Ensure the registered nurse has completed an annual medication competency.

Timeframe (days): 60 (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: PA Low

Evidence:

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements with the exception of one new admission. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. As required medication orders (PRN) all record indications for use. Thirteen of fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Finding:

A recently admitted resident's GP has typed out a list of medications for the new resident and signed and dated the bottom of the sheet. It is not clear which medications are regular or PRN and medication orders are not signed for individually.

Corrective Action:

Ensure all residents have an individual medication chart which clearly describes the medications prescribed, dosage, is signed and date for each individual order, clearly states the time of administration and uses, for and non-regular items.

Timeframe (days): 60 (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:

All meals are prepared and cooked in the facility kitchen. Meals are prepared by the owner/manager or care staff for the 14 residents. A menu has been developed, is seasonal and has been reviewed by a registered dietician. The kitchen is of appropriate size and includes a free standing range with cook tops, fridge, freezer, small pantry and store room. Resident's dietary requirements are catered for including pureed and soft. No residents are receiving supplements.

A dietary requirements form and nutritional assessment is conducted on admission and as changes occur. Food is served directly from the kitchen servery bench to the dining room.

The maintenance person conducts weekly fridge and freezer temperatures. These were sighted. Food stored in the fridge and freezer is covered and labelled with a day of the week sticker. Advised that left over food is stored for 48 hours then discarded. The kitchen has a pantry with extra food stores - enough for three days if required in an emergency.

A registered nurse conducts nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues. There are currently no residents with weight loss issues. All weights reviewed are stable as evident in four of five files reviewed (one recent admission). Dietary information is documented in the long term care plan if there is an identified nutritional issue.
 Resident weights are monitored monthly or more frequently if required.
 The daily menu is discussed with residents and alternatives are offered if requested.
 Resident satisfaction survey which includes food and meal service, was conducted in 2012. Food and meals are daily topics of discussion with management. The residents were observed enjoying a bbq lunch on the day of audit. Previous audit finding relating to a resident receiving pureed meals has been addressed by the service.

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

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

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

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

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

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

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

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: <p>There are documented policies and procedures in the Infection control programme which relates to hazard and waste management: blood/serum/body fluid/needle stick protocol and reporting forms; management of blood/body fluid spills; disposal of waste. The health and safety manual includes management of incidents and accidents, and incident reporting and analysis. All accidents/incidents are reported on the accident report form and followed through appropriately and discussed at management meetings and staff meetings.</p> <p>Previous certification audit identified that safe chemical handling training had not conducted since 2010. (#1.4.1.1). Safe chemical handling training has been provided in September 2012 and covered management of hazardous waste. Waste and hazardous substances training included in infection control training and at orientation of new staff. Caregivers (two) and a registered nurse are able to describe the safe handling of waste - hazardous and non-hazardous. All accidents/incidents are reported on the accident/incident report form and followed through appropriately and discussed at staff meetings. Chemicals are stored safely in a locked storage room. This is an improvement from the previous audit which has been addressed and monitored.</p>

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

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

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

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 service displays a current building warrant of fitness which expires on 1-June 2014.

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:

Restraint minimisation is overseen by a restraint coordinator who is the registered nurse. There are currently no residents identified as requiring restraint or enablers. Policy states that the use of enablers is voluntary and is requested by the resident. Restraint/enabler training is included in the in-service training plan for 2013 – last conducted in June 2012. Challenging behaviour in-service conducted in April 2013.

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 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: PA Low

Evidence:

Previous certification finding relating to infection control education remains unmet. The infection control coordinator (registered nurse) has been in the role of IC coordinator since commencing employment in January 2014 and has yet to attend infection control education. The infection control co-ordinator has good external support from an IC consultant and the expert infection control specialist team at SCL in Christchurch. The IC consultant is able to provide in-service education to staff, however, this has not been conducted since 2011. The infection control team is representative of the facility. All staff complete an infection control competency at orientation. Infection control education occurs as part of staff meetings, through hand washing audits. There is a registered nurse on duty eight hours per week and on call at all other times enabling prompt notification of pathology results. There are adequate resources to implement the infection control programme for the size and complexity of the organisation.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: PA Low

Evidence:

The infection control coordinator (registered nurse) has been in the role of IC coordinator since commencing employment in January 2014 and has yet to attend infection control education. The infection control co-ordinator has good external support from an IC consultant and the expert infection control specialist team at SCL in Christchurch. The IC consultant is able to provide in-service education to staff, however, this has not been conducted since 2011. The infection control team is representative of the facility. All staff complete an infection control competency at orientation. Infection control education occurs as part of staff meetings, through hand washing audits.

Finding:

a) The infection control coordinator (registered nurse) has been in the role of IC coordinator since commencing employment in January 2014 and has yet to attend infection control education; b) staff in-service relating to infection prevention and control not provided in past two years.

Corrective Action:

a) Registered nurse to attend infection control education and b) staff to be provided with in-service relating to infection prevention and control.

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

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 surveillance is an integral part of the infection control programme and is described in Elms Court infection control policy. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility

Infection surveillance is an integral part of the infection control programme and is described in the infection control policy.

Monthly infection data is collected for all infections. All infections are entered on to an infection register. This data is monitored and evaluated. Outcomes and actions are discussed at handover, at staff meetings and at management meetings.

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