# The Rest Homes Limited

## Current Status: 24 March 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

Ascend has been rebranded as Makoha Rest Home and the service provides care for up to 34 resident’s rest home residents and residents with sensory, physical, intellectual disability. There is a mission statement documented with new documentation of the mission statement in the pamphlets, which state ‘best place for your loved ones’.

The organisation has a written quality and risk management programme described in the policy manual and all aspects of the quality programme are reviewed through the staff meeting. There are business goals documented in the business risk assessment and management plan.

The director (a psychiatrist) has owned the service for two years and the operational management of the facility is led by a clinical nurse manager who has completed a post graduate diploma in speciality practice (Pacific health) and has been with the service for two years.

The facility has been extensively refurbished and modernised. Nineteen of twenty improvements required at the last audit have been addressed including: documentation of personal property/valuables, training around abuse and neglect and cultural safety, review of objectives relating to addressing issues related to Maori, resolution of complaints, to the quality and risk management programme including incident reporting, current practicing certificate for all relevant staff on file, annual performance appraisals, signed agreements for residents, initial assessments, interventions, short term care plans, medication, freezer temperature and to maintenance issues.

One opportunity for improvement remains since the last audit around reviewing the menu by a dietitian.

This audit identifies improvements required to the following: Review and implementation of an activities plan, and to staff medication competencies.

## Audit Summary as at 24 March 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 24 March 2014

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| 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. |

### Organisational Management as at 24 March 2014

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

### Continuum of Service Delivery as at 24 March 2014

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

### Safe and Appropriate Environment as at 24 March 2014

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| 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 24 March 2014

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| 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 24 March 2014

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## Introduction

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

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

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

## Audit Report

|  |  |
| --- | --- |
| **Legal entity name:** | The Rest Homes Limited |
| **Certificate name:** | The Rest Homes Limited |

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| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Ascend Quality Care | | | |
| **Services audited:** | Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical; Residential disability services – Sensory | | | |
| **Dates of audit:** | **Start date:** | 24 March 2014 | **End date:** | 24 March 2014 |

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| **Proposed changes to current services (if any):** |
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| **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** | 6 |
| **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** | 2 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 8 | Total audit hours off site | 8 | Total audit hours | 16 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 4 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 11 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | 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 the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 29 April 2014

## Executive Summary of Audit

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| **General Overview** |
| Ascend has been rebranded as Makoha Rest Home and the service provides care for up to 34 resident’s rest home residents and residents with sensory, physical, intellectual disability with 14 residents on the day of the audit. There are three residents under the age of 65 years, two identified as physical disability, one with intellectual disability. There is a mission statement documented with new documentation of the mission statement in the pamphlets, which state ‘best place for your loved ones’.  The organisation has a written quality and risk management programme described in the policy manual and all aspects of the quality programme are reviewed through the staff meeting. There are business goals documented in the business risk assessment and management plan.  The director (a psychiatrist) has owned the service for two years and the operational management of the facility is led by a clinical nurse manager who has completed a post graduate diploma in speciality practice (Pacific health) and has been with the service for two years.  The facility has been extensively refurbished and modernised.  Nineteen of twenty improvements required at the last audit have been addressed including: documentation of personal property/valuables, training around abuse and neglect and cultural safety, review of objectives relating to addressing issues related to Maori, resolution of complaints, to the quality and risk management programme including incident reporting, current practicing certificate for all relevant staff on file, annual performance appraisals, signed agreements for residents, initial assessments, interventions, short term care plans, medication, freezer temperature and to maintenance issues.  One opportunity for improvement remains since the last audit around reviewing the menu by a dietitian.  This audit identifies improvements required to the following: Review and implementation of an activities plan, and to staff medication competencies. |

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| **Outcome 1.1: Consumer Rights** |
| Makoha Rest Home provides care and support that focuses on the individual with residents and relatives praising the services provided. Complaints processes are implemented and complaints and concerns are actively managed and documented with a complaints register completed by the owner/manager. The service encourages the documentation of verbal complaints as a tool to improve quality of service delivery. Improvements required at the last audit have been made to documentation of personal property/valuables, training around abuse and neglect and cultural safety, review of objectives relating to addressing issues related to Maori and resolution of complaints. |

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| **Outcome 1.2: Organisational Management** |
| Ascend has been rebranded as Makoha Rest Home and it provides care for up to 34 resident’s rest home residents and residents with sensory, physical, intellectual disability with 14 residents on the day of the audit. There is a new mission statement documented.  The quality and risk management programme has been now fully implemented with evidence of improvements made as a result of data collected.  The clinical nurse manager provides leadership and oversight of all operations and reports to the director. She is supported by three enrolled nurses and other caregivers who are knowledgeable and skilled. The general practitioner has confidence in the service.  Improvements required at the last audit have been made to the following: complaints and restraint now linked to the quality programme, the business plan, feedback from residents/family, staff meetings now held monthly, corrective action plans, incident reporting, practicing certificates held on file held on file, annual performance appraisals completed no use of white out. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a documented assessment process and there is an information pack available for residents/families at entry. Care plans are individualised and evaluated six monthly. The service facilitates access to other medical and non-medical services. Meals are prepared on site by the chef and individual and special dietary needs are catered for. Residents and family interviewed responded favourably to the food that was provided. Improvements required at the last audit have been made to signed agreements for residents, initial assessments, interventions, short-term care plans, medication and freezer temperatures.  Improvements are required to the following: medication competencies and review and implementation of the activities plan.  An improvement required at the previous audit to dietitian review of the menu continues. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Makoha Rest home holds a current warrant of fitness. There is a planned maintenance programme in place. All equipment is calibrated. There is sufficient space to allow the residents to freely move around the facility using the mobility aids with outdoor areas for people to meet. Extensive refurbishment and modernization of the facility has been made and residents, staff, the general practitioner and family praised the environment. All previous requirements required at the last audit have been addressed as a result of the refurbishment. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has a restraint free philosophy and there are no restraints and only one enabler used (bedrail). All staff interviewed are knowledgeable around restraint, enablers and management of challenging behaviours. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control policies and procedures are documented. The infection control co-ordinator (registered nurse i.e. clinical nurse manager) is responsible for implementing the infection control programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery. |

## Summary of Attainment

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 19 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 46 | 0 | 2 | 1 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 52 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 are meaningful to the consumer. | PA Low | The diversional therapist documents a limited programme however this does not include one to one activities (residents state that these do happen) and do not include all aspects of cognitive, physical and other aspects of health. | Document and implement an extensive activities plan. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Two staff giving medications do not have a current medication competency. | Ensure that staff administering medication have an annual competency completed. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.1 | Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The service is not able to provide evidence that the menu has been reviewed by a dietitian but the chef states that the dietician is in the process of reviewing the menu. | Ensure that the menu is reviewed and approved by a dietitian. | 60 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The personal property/valuables form is completed in five of five files reviewed. The improvement required at the previous audit has been addressed.  Staff have received training around abuse and neglect in March 2014. Staff interviewed including the enrolled nurse, the clinical nurse manager and the diversional therapist state that attitudes have improved and staff have worked to address negativity. Changes in the building have also helped to improve staff attitudes.  Six of six residents and two of two family members interviewed state that staff are friendly and supportive. The improvement required at the previous audit has been addressed. |

##### Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

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

##### Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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

#### Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Objectives relating to addressing issues related to Maori are documented in the guidelines for the provision of culturally safe services for Maori residents. Cultural assessments have been introduced for Maori residents who identify as Maori and a file reviewed for a Maori resident includes a cultural assessment, documentation of iwi and introduction of foods that the resident brings in that meet his need.  Staff have had training around cultural safety in May 2013.  There are Maori staff in the service including the enrolled nurse and clinical nurse manager interviewed and those interviewed can describe how cultural beliefs for Maori are upheld. There are five Maori staff and all are able to speak in Te Reo.  The clinical nurse manager has completed a postgraduate diploma in speciality care - Pacific health and principles are linked into the support for Maori. The clinical nurse manager has also completed a paper at the Wananga o Aotearoa around Maori health in 2013. The improvement required at the previous audit has been addressed. |

##### Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| 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.  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 through the agreement and in discussion with the clinical nurse manager.  D16.4b Two of two relatives state that they are always informed when their family members health status changes. The facility has an interpreter policy and procedures available for access to interpreter services and residents (and their family) are provided with this information at the point of entry. Interpreters are available through the DHB if required. There have been no residents who require interpreting services. D11.3 The information pack is available in large print if required and advised that this can be read to residents.  Six of six residents and two of two family members interviewed state that there is good communication with the clinical nurse manager and other staff.  All family members’ state that they are informed when there is an incident. Six of seven incident forms reviewed include documentation that the family has been informed with one indicating that it is not necessary to call the family. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. A complaints register is maintained and this is current with complaints documented for 2013 (none for 2014). One complaint was tracked for monitoring purposes to ensure that it is actioned according to timeframes in the policy and these identify that a complaint is resolved in a timely manner. Tracking indicates that it is resolved within timeframes as per the policy.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. Six of six residents and two of two family members interviewed confirm that they know how to make a complaint and all state that there is no reason for them to make a complaint but feel that any concerns would be resolved. The clinical nurse manager confirms that there have been no complaints with the Health and Disability Commissioner, Ministry of Health or the District Health Board since the last audit. Full documentation of actions taken to resolve the issues is documented. The improvement required at the previous audit has been addressed. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Ascend has been rebranded as Makoha (meaning tranquil, undisturbed, compassionate, gentle, kind hearted, considerate) Rest Home. Makoha Rest Home provides care for up to 34 resident’s rest home residents and residents with sensory, physical, intellectual disability with 14 residents on the day of the audit. There are three residents under the age of 65 years, two identified as physical disability, one with intellectual disability and none with sensory disability.  The organisation has a written quality and risk management programme described in the policy manual.  There is a mission statement documented with new documentation of the mission statement in the pamphlets, which state ‘best place for your loved ones’.  There are business goals documented in the business risk assessment and management plan. The director reviews the plan annually. The plan is reviewed by the clinical nurse manager annually - annual report sighted for 2013.  The director has owned the service for two years, the director is a psychiatrist.  The clinical nurse manager clinical nurse manager is a registered nurse with a post graduate diploma in speciality practice (Pacific health) and has been with the service for two years. The clinical nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home and home for people with disabilities. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Makoha Rest Home has a quality and risk management system that is overseen by director and the clinical nurse manager.  Discussions with the clinical nurse manager, the enrolled nurse and the caregiver and review of meeting minutes demonstrates staff involvement in quality and risk activities.  There are monthly staff meetings and meeting minutes indicate that there is discussion around topics relevant to each meeting. All aspects of the quality and risk management programme are reviewed through the staff meeting.  Resident meetings are held two to three monthly and facilitated by the diversional therapist. Minutes are documented.  There are satisfaction surveys annually (last in March 2013 with results currently being collated to compare with the 2014 data) and the service is currently distributing questionnaires for 2014.  D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and reviewed for the sector standards and contractual requirements and the clinical nurse manager and an independent consultant review these to align with standards. The quality and risk system is documented and links with associated policies/procedures.  There is a document control process implemented that includes a review date and sign off by the clinical nurse manager.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is addressed through the staff monthly meetings at times. A hazard register is documented and hazard identification forms identify that any hazards are addressed in a timely manner and discussed at meetings.  D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.  D19.2g Falls prevention strategies such as lowering resident’s beds, staff supervision and a review of any incidents around falls are implemented.  There are implemented internal audits and audits identify corrective actions required with sign off of resolution in a timely manner.  There are three monthly newsletters and these inform family and the community of progress in the service.  The service has refurbished and modernised the facility with rebranding completed. The general practitioner interviewed confirmed that the only suggestion for improvement in the past had been to paint and modernise the building and now this has been done, states that there are no quality improvements currently required from his perspective. A van has also been purchased in response to resident feedback and this will be used to support residents to access the community.  The following improvements required at the last audit have been addressed: complaints and restraint are linked to the quality management system, the business plan reflects current objectives, the audit schedule is implemented, residents/family provide input through satisfaction surveys, there are now monthly instead of quarterly staff meetings and corrective action plans are documented with evidence of resolution including follow up of issues and suggestions put forward by residents at the resident meetings. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the Ministry of Health. 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 reports are completed for each incident/accident with immediate action noted and any follow up action required.  Meeting minutes from the staff meetings reflect discussion of incidents and accidents. A review of incident/accident forms for Makoha Rest Home (seven reviewed) identifies that all incident forms include follow-up actions taken. The clinical nurse manager has reviewed these. All seven incidents reviewed were identified in resident files and all incidents are recorded on incident forms and managed as part of the incident reporting and management process. The improvement required at the last audit has been addressed. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Five staff files were reviewed including the clinical nurse manager, enrolled nurse, caregiver, chef and receptionist.  D17.7d: There are implemented medication competencies for all relevant caregivers/enrolled nurses and the clinical nurse manager around medication and evidence in staff files confirms that these have been completed for relevant staff. Five of five staff files include a signed contract, application form, evidence of training, referee checks, police checks and job description.  Five of five files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home level care with the service having a low turnover rate. The clinical nurse manager confirms that she has completed at least eight hours training a year (training records sighted). Six of six residents and two of two family members interviewed state consistently that staff are competent, caring and knowledgeable. There is an annual training plan and the enrolled nurse and caregiver interviewed confirm that they find the training valuable.  Current practicing certificates are sighted for the clinical nurse manager, doctors, dietician and physiotherapist. The improvement required at the last audit has been addressed. There are training sessions around specific aspects of the service e.g. infection control, continence, brain injury, medication, aged concern and elder abuse, blood glucose monitoring, continence, diabetes, manual handling, death and dying and rights. Staff interviewed including the clinical nurse manager and enrolled nurse have a sound knowledge of what should be provided. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff levels and skill mixes are appropriate for the service of this type. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.  There are 11 staff employed in the service including the clinical nurse manager, three enrolled nurses, two chefs, one receptionist/diversional therapist, six caregivers. The brother of the director supports on-going completion of maintenance.  The service contracts with allied health professionals on an as required basis.  Staffing is as follows (14 current residents): AM: Two caregivers (7.30am-1pm and 7am-3pm) and the clinical nurse manager 9am-5pm Monday to Friday.  PM: One caregiver 3pm to 11pm.  Night: One caregiver from 11pm to 7.00am.  The three enrolled nurses support the clinical nurse manager in ensuring that there is good practice.  Six of six residents and two of two family members interviewed report there are always enough staff on duty and all praised the staff for the care and support provided.  Staff turnover is low. The director is available. |

##### 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.

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

#### Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Records reviewed do not have any white out fluid used. The improvement required at the previous audit has been addressed. |

##### Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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

##### Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a signed resident agreement held on the premises for every resident – sighted on the day of the audit. The improvement required at the last audit has been addressed. |

##### Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.2, 3, The clinical nurse manager completes the assessment on admission, with the initial care plan completed within 24 hours of admission in five of five files reviewed. Within three weeks, the long term care plan is developed as evidenced in all rest home resident files sampled.  Files reviewed includes a signed agreement.  There is evidence of resident and/or family/EPOA involvement in the care planning process.  The diversional therapist completes an activities assessment involving the resident and their family soon after admission. An activity plan is developed (refer 1.3.7). Care plans are used by caregivers to ensure care delivery is in line with the residents assessed needs.  A range of assessment tools available for use on admission includes continence, falls pressure area and dietary assessments. An assessment is expected to be completed six monthly (refer 1.3.4.2).  There is a verbal handover for staff at the beginning of each shift (sighted with relevant information handed over). Any resident concerns or events are communicated to the oncoming staff. The enrolled nurse and caregiver can describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery.  All five files identified integration of allied health including the general practitioner.  Medical assessments are completed within 48 hours of admission in five of five rest home resident files sampled. The general practitioner completes routine three month visits and medication reviews or more frequently as documented and required. The general practitioner states that there is ‘good quality of care’ and confirms that the general practitioner is informed if there are significant issues noting that minor issues or changes are managed within the ability of the clinical nurse manager and staff.   Tracer methodology; Rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer 2: Physical disability  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer 3: Intellectual  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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

#### Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial nursing assessment is fully completed for every resident (five of five sighted as being completed within 24 hours but usually on the day of admission. Falls assessments are completed for all residents (five of five reviewed) with evidence that all are reviewed six monthly.  Behaviour assessments are completed for residents who present behaviours that challenge – one relevant sighted on the day of the audit.  All assessments form the basis of and link to care plans sighted.  The improvements required at the last audit have been addressed. |

##### Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

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

#### Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Five of five care plans sampled have interventions that correlate to identify needs. Examples include weight loss, pressure area management and the use of short term care plans for short term needs. The improvement required at the last audit has been addressed. |

##### Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' care plans are completed by the clinical nurse manager. When a resident's condition alters, the clinical nurse manager initiates a review and if required, general practitioner or specialist consultation – sighted in files reviewed particularly for one resident who had a knock to the leg. The general practitioner confirms that the general practitioner is notified when required.  The enrolled nurse and caregiver interviewed state that they have all the equipment referred to in support plans necessary to provide care, including chair scales, continence products that are individualised, pressure area mattresses, lifting belts, wheelchairs, gloves, aprons and masks. All products and equipment was sighted as being calibrated annually and checked on the day of the audit.  The service has access to physiotherapy services for equipment assessment and advice.  D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. Staff report that there are adequate dressing supplies. There are no residents currently with wounds.  Wound care plans are able to be described for minor skin tears and wounds.  Dietary profile forms that include specific dietary requirement, likes and dislikes are completed on admission for all new admissions. Dietary profiles are reviewed six monthly. Copies are sent to the chef. The chef confirms dietary profiles and any special requests are received from the clinical nurse manager. The chef is aware of any residents with weight loss and a high calorie diet is provided as described for one resident . All residents are weighed monthly and more frequently if there is a need for weight monitoring. The general practitioner confirms that the doctor reviews residents weight loss at the three monthly review or earlier if notified of weight loss by the registered nurse. The podiatrist visits six weekly. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service employs a diversional therapist for 30 hours a week.  There are visits from community groups including pet therapy and entertainers.  The service is purchasing a van.  The diversional therapist completes a social assessment as soon as practical after admission of a new resident and develops an activity care plan with resident and family involvement. The care plan is reviewed six monthly. Attendance sheets are maintained for each resident. Progress notes are written monthly or when significant events occur into the integrated file. The diversional therapist documents a limited programme however this does not include one to one activities (residents state that these do happen) and do not include all aspects of cognitive, physical and other aspects of health. Residents state that not all activities are relevant to them and one resident state that one to one activities only occur at times.  The diversional therapist facilitates the resident meeting.  An opportunity for improvement is identified around documentation and implementation of a more extensive activities 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The diversional therapist documents a limited programme and activities are offered to residents during the week. |
| **Finding:** |
| The diversional therapist documents a limited programme however this does not include one to one activities (residents state that these do happen) and do not include all aspects of cognitive, physical and other aspects of health. |
| **Corrective Action:** |
| Document and implement an extensive activities plan. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical nurse manager completes a review of the long term care plan six monthly. Changes to health status are included on the care plan.  The service uses short term care plans to document specific care e.g. there is one resident who has a short term care plan for pain.  The general practitioner reviews the resident three monthly and each resident has a review of weight, blood pressure and pulse monthly.  D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. All short term needs are addressed in short term care plans and short term care plans are reviewed regularly. The improvement required at the last audit has been addressed. |

##### 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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are policies and procedures in place for all aspects of medicine management. These comply with the current safe practice guidelines. During the audit a medication round was observed and practice was seen to be safe and according to the policies and procedures. The enrolled nurse completing the medication round is able to describe the process as per the policy. A blister pack system is in place and medicines are supplied by a local pharmacy. PRN medications are supplied in blister packs. On arrival from the pharmacy the clinical nurse manager or enrolled nurse checks medicines against the prescription chart – sighted. There is a medication fridge and the temperature is checked and recorded weekly. There is a controlled drug safe, which complies with the drug regulations. The controlled drug register was verified as accurate with a check of controlled drug balances. Medicines are stored securely in a locked cupboard and trolley, which is supervised by the enrolled nurse when administering medication. The keys are held on the person of the staff member administering medications. Allergies are recorded on the prescription charts and in the clinical files. Any errors are reported via the incident accident reporting system. Review of medication errors show that there are few errors and these are always investigated and followed up by the clinical nurse manager.  A total of ten medication prescription and administration records were sighted. All comply with the requirements. Specimen signatures are recorded. There is a policy and procedure in place for the safe self-administration of medicines, however at this time no residents self-administer medication. The following improvements required at the last audit have been addressed: All medication charts are reviewed at least three monthly by the general practitioner, medicines are administered as prescribed and controlled drug checks occur weekly. Staff are trained by the clinical nurse manager in medication administration procedures. Before they are able to administer medicines, they are required to sit a competency test and this is expected to be completed annually. Two staff giving medications do not have a current medication competency. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Staff are required to have an annual competency. Staff have had training in January 2013 around blood glucose monitoring and medication in May 2013. |
| **Finding:** |
| Two staff giving medications do not have a current medication competency. |
| **Corrective Action:** |
| Ensure that staff administering medication have an annual competency completed. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Fluids are provided with each meal and afternoon tea and supper is provided.  Any dietary requirements are identified on admission by the clinical nurse manager and the chef interviewed is familiar with dietary needs. The chef interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what plate to use, if food should be cut up, and the type and portion size of the meal.  The kitchen is clean and has cooking appliances for the numbers to be catered for. All food supplies are delivered on a regular basis to meet the menu requirements.  Food is stored safely, labelled with contents and expiry dates are monitored. There are daily temperature recordings of the freezers and chiller and food temperatures are recorded with documentation indicating that all food temperatures are in the correct range.  All kitchen staff have attended food safety training and completed the necessary requirements.  Two of two family members interviewed confirmed that the food meets the approval of their family member from their observation and residents appeared to enjoy the meal at lunchtime. Six of six residents state that they enjoy the meals. Meals on the day of the audit are appetising and hot.  Temperatures of hot food is taken at each meal.  Food is covered and dated in the fridge/freezers and all food is off the floor in the pantry.  The kitchen is staffed by two chefs both of whom have City and Guild qualifications.  The freezer is maintained at a safe temperature with the freezer temperature corrected by an external consultant. The improvement required at the last audit has been addressed. There is a summer winter menu and the menu is in the process of being reviewed by a dietician as stated by the chef. The improvement required at the last audit continues. |

##### 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a summer winter menu. There are two qualified chefs in the kitchen and both provide oversight of the menu to ensure that there is a balanced approach. Attention is paid to specific needs and any weight loss is monitored and catered for. |
| **Finding:** |
| The service is not able to provide evidence that the menu has been reviewed by a dietitian but the chef states that the dietician is in the process of reviewing the menu. |
| **Corrective Action:** |
| Ensure that the menu is reviewed and approved by a dietitian. |
| **Timeframe (days):** 60 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a current building warrant of fitness that expires 24 May 2014. There is a reactive and planned maintenance system and the brother of the director is responsible for completing some maintenance with contractors called as necessary.  Residents are observed moving freely about the home and accessing the communal areas with ease.  ARC D15.3; There is adequate equipment available for the rest home including a pressure area mattresses, lifting belts, wheelchairs, mobility aids, chair scales. Equipment has been calibrated in 2013.  The facility has been completely refurbished and modernised with all rooms having a shared unsuited. The family members and residents state that it is like a ‘family home’ and they enjoy living in it. The site is safe both inside and out with rails appropriately place to support residents.  There are deck areas outside for residents to use. Surfaces were checked on the day of the audit to ensure that they were not slippery.  Residents, general practitioner, family and staff praised the environment for being a ‘quality’ environment.  All maintenance issues have been addressed through the refurbishment. The improvements required at the last audit have been addressed. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The policy around restraint and enablers is applicable to the type and size of the service (rest home).  The service has a restraint free philosophy.  Restraint is not used and there are currently one enablers used.  The policies and procedures are comprehensive, including definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. Strategies are in place to minimise the use of restraint including mobility aids and supervision of residents. The enrolled nurse and caregiver interviewed confirm knowledge of restraint, enablers and management of challenging behaviours. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control surveillance policy describes the surveillance programme. The staff meeting includes discussion of infection control and discussion of the monthly data. All infections are collected via the infection report form. There is a collated report of infections monthly including site and use of antibiotics and a graph generated.  Trends and individual outcomes are noted and acted upon by the clinical nurse manager as stated by the clinical nurse manager. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.  The infection control coordinator is the registered nurse.  Staff interviewed including the caregiver and enrolled nurse confirm knowledge of best infection control practice and of surveillance data. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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