Kaiapoi Lodge Residential Care Limited

Current Status: 4 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

Kaiapoi Lodge cares for residents requiring hospital and rest home level care. On the day of the audit there were 28 residents receiving hospital level care and 19 receiving rest home level care. The CEO is supported by the quality control coordinator (who is also the hospital clinical coordinator), and a clinical coordinator who is a registered nurse and has been with the service for 20 years.

The two shortfalls identified at the previous audit have been addressed. These were around staff meeting minutes and performance appraisals.

This audit has identified further improvements required around orientation records, informing families of incidents and controlled drug management.

Audit Summary as at 4 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 4 March 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

Organisational Management as at 4 March 2014

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

Continuum of Service Delivery as at 4 March 2014

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

Safe and Appropriate Environment as at 4 March 2014

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

Restraint Minimisation and Safe Practice as at 4 March 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Infection Prevention and Control as at 4 March 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Kaiapoi Lodge Residential Care Limited
Certificate name:	Kaiapoi Lodge Residential Care Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Kaiapoi Lodge
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 4 March 2014 **End date:** 4 March 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:	47

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	4
Other Auditors	XXXXX	**Total hours on site**	8	**Total hours off site**	4
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	1

Sample Totals

Total audit hours on site	16	Total audit hours off site	9	Total audit hours	25

Number of residents interviewed	6	Number of staff interviewed	11	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	18	Total number of staff (headcount)	48	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	

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 Thursday, 3 April 2014

Executive Summary of Audit

General Overview
Kaiapoi Lodge cares for residents requiring hospital and rest home level care. On the day of the audit there were 28 residents receiving hospital level care and 19 receiving rest home level care. The CEO is supported by the quality control coordinator (who is also the hospital clinical coordinator), and a clinical coordinator who is a registered nurse and has been with the service for 20 years. The two shortfalls identified at the previous audit have been addressed. These were around staff meeting minutes and performance appraisals. This audit has identified further improvements required around orientation records, informing families of incidents and controlled drug management.

Outcome 1.1: Consumer Rights
There is an open disclosure policy and an interpreter's policy in place. Staff have a good understanding of these policies. Interpreter services are available if needed. Families of the resident's report the management team and staff keep them informed of their family member's status. There is an improvement required around informing families of incidents. There is a complaints policy supporting practice and a complaints register. Resident and family interviews confirmed their understanding of the complaints process. Complaints reviewed show thorough investigation and letters regarding outcomes to complainants within appropriate timeframes.

Outcome 1.2: Organisational Management
There is a business plan with documented goals. There is evidence that the quality system continues to be implemented at Kaiapoi Lodge. The service's policies are reviewed two yearly. Staff have access to manuals in hard copy. Policies are up to date. Clinical guidelines are in place to assist care staff and registered nurses. The service collects internal data for monitoring purposes. Staff are informed of internal audit results. There is evidence of corrective action plans being implemented for internal audits. The service has a risk management programme. There is a risk register in place. All clinical events are being documented including pressure areas. Monthly aggregation of incident data is undertaken and reported at quality assurance and staff meetings. Practising certificates are held in a central location for all registered, clinical staff. A recruitment, selection and appointment of staff policy are in place. There is an improvement required around orientation records. A comprehensive training schedule is in place, and being implemented. Staffing policies are in place that includes a documented rationale for staffing the service. Staffing is designed to match the needs of the residents.

Outcome 1.3: Continuum of Service Delivery
The services are coordinated to promote continuity of service delivery and residents and family members are involved in all stages of service provision. Residents' care plans are completed by the clinical coordinator in the rest home and the RNs and the clinical coordinator in the hospital in conjunction with inputs from caregivers, residents and family members. Document review showed that the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. Care plan interventions give clear direction to caregivers who provide daily care to residents. Additional input from professionals or specialists is obtained if this is required.

The activities officer works 30 hours a week across rest home and hospital. There is a monthly activities program that is appropriate to the functional capabilities of residents. Residents are able to participate in indoor and external activities. There are also visits from community groups.
Policies and procedures clearly identify the responsibility, accountability and scope of practice of staff and residents during medicine management. RNs in the hospital and medicine competent caregivers in the rest home administer medicines. Staff education programme includes medication training and staff medication competency assessments are current. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. The audit identified an improvement required around management of controlled drugs.
The food is cooked on site and the menu range is varied and appropriate to the resident group. Personal preferences/likes/dislikes are noted on admission and communicated to the kitchen. Resident and family interview confirmed satisfaction with food services.

Outcome 1.4: Safe and Appropriate Environment

The facility building warrant of fitness was sighted and is current. Preventative and reactive maintenance occurs.

Outcome 2: Restraint Minimisation and Safe Practice

The service has restraint and enabler registers in place that include the type of restraint/enabler, date commenced and comments. The registers are reviewed at the quality assurance meetings and annual restraint approval group meetings. There are four restraints and no enablers in use at Kaiapoi Lodge.

Outcome 3: Infection Prevention and Control

There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the quality and risk management meetings and outcomes are reported to staff through nursing and staff meetings. Infection control surveillance is established that is appropriate to the size and type of services.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	2	1	0	0
Criteria	0	38	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Seven of 17 incident forms sampled (from across the rest home and hospital) do not document that family were informed following the incident.	Ensure family are informed following all incidents.	180
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Two of seven staff files sampled do not contain orientation records.	Ensure that all new staff complete an orientation and that a record of this is maintained.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation,	PA Moderate	The audit identified issues around management of controlled drugs. 1) A controlled drug issued in 11 June 2012 and advised that the resident brought the controlled	Ensure that physical stock takes of controlled drugs is completed at least six monthly and expired medications are returned to the pharmacy.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		protocols, and guidelines.		drug (Morphine LA) to the facility on the day of admission and it was registered in the controlled drug book. The medication expired in September 2013. The controlled drug was not administered and not charted in the resident's drug chart by the GP. 2) Six monthly physical stock takes of controlled drugs is not completed.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: PA Low
Evidence: Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Seventeen incidents/accidents forms were viewed for 2013 (from two resident files) and February 2014. The form includes a section to record family notification. Ten of seventeen forms reviewed indicated family were informed. This is an area requiring improvement. Kaiapoi Lodge has an open disclosure policy. On interview six residents (three rest home and three hospital), four family members (one rest home and three hospital) and seven caregivers (five rest home and two hospital) all stated that family are informed following changes in the resident's health status. The registered nurse and clinical coordinator interviewed stated that they record contact with family/whanau in resident's files. Contact records were documented in all five resident files reviewed. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files. A residents/relatives meeting occurs three monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. There is a policy that describes the availability of interpreter services when required. D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Four of four family members interviewed stated that they are always informed when their family members health status changes. D11.3: The information pack is available in large print and advised that this can be read to residents.

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

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

Attainment and Risk: PA Low
Evidence: Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A

specific policy to guide staff on the process to ensure full and frank open disclosure is available. Seventeen incidents/accidents forms were viewed for 2013 (from two resident files) and February 2014. The form includes a section to record family notification. Ten of 17 forms reviewed indicated family were informed. Kaiapoi Lodge has an open disclosure policy. On interview six residents (three rest home and three hospital), four family members (one rest home and three hospital and seven caregivers (five rest home and two hospital) all stated that family are informed following changes in the resident's health status.
Finding: Seven of 17 incident forms sampled (from across the rest home and hospital) do not document that family were informed following the incident.
Corrective Action: Ensure family are informed following all incidents.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with six residents (three rest home and three hospital) and four family members (one rest home and three hospital), inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints There is a complaints register. Each of the five complaints for 2013 were reviewed. Four were from the same resident/family and all were investigated and found to be unsubstantiated. All complaints were well documented and investigated with the complainant informed of the outcome. Verbal and written complaints are documented. All complaints are recorded in the complaints register.

Discussions with six residents and four family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with seven caregivers (five rest home and two hospital) stated that concerns/complaints were discussed at monthly staff meetings.
D13.3h: A complaints procedure is provided to residents within the information pack at entry.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

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

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

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

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

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA
Evidence: Kaiapoi Lodge has been owned and operated by the CEO for the past 24 years. The service has up to 49 beds. At the time of the audit, there were 19 residents receiving rest home level care and 28 residents receiving hospital level care. Two of the hospital level residents are under a palliative care contract. Kaiapoi Lodge has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The quality process being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Monthly staff meetings and three monthly quality assurance meetings discuss key components of the quality system and any issues are reported (minutes viewed). There is an internal audit schedule that aligns with the business plan and is implemented. The facility is owned by the CEO and has been for the last 24 years. The quality control coordinator is a registered nurse who has been involved with the facility for 20 years and has worked full time at the facility for the past six years. They are supported by a clinical coordinator who is a registered nurse with a postgraduate diploma in gerontology who has worked at the facility for 20 years. ARC, D17.3di (rest home), D17.4b (hospital): The management team attend monthly DHB interface meetings and a Healthcare Compliance representative has provided mentoring twice in the past year for two hours on each occasion. There is RN cover in the facility 24/7.

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 facility has a quality framework that is being implemented. The CEO and quality control coordinator are directly involved in operations at the facility and the clinical coordinator supports them in this role. There is a current business plan that includes objectives/goals and a quality plan, which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (seven caregivers, one RN, the clinical coordinator, the quality control coordinator and the CEO) inform an understanding of the quality activities undertaken at Kaiapoi Lodge. Resident meetings occur three monthly (minutes viewed). Six of six residents interviewed are aware meetings are held. Bi annual satisfaction surveys are undertaken and results analysed. The April 2012 survey report indicted very positive views of the service. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service. D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans. D10.1: Following the death of a resident policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as physiotherapy reviews, instruction around prevention in care plans and education for staff are implemented. Policies and procedures are in place with evidence of review. The quality control coordinator manages quality systems. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. Restraint and enabler usage is documented. Kaiapoi Lodge has four residents with restraints and no residents using enablers. There is a 2013 and 2014 internal audit programme, which includes all aspects of service delivery and organisational procedures. All issues found in the 2013 audits have evidence of corrective actions having been completed. Results of audits are discussed in quality assurance and staff meetings. This is an improvement since the

previous audit.
Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is reported through to quality and staff meetings. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been regularly completed and documented in the quality/staff meeting minutes. All staff interviewed could describe the corrective action process.
Kaiapoi Lodge has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Seven caregivers (five rest home and two hospital) interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

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

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

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

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

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

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

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

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: 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: There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the quality control coordinator or clinical coordinator, who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and quality assurance meetings. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. A sample of 17 incidents/accidents from two resident files and February 2014 were viewed. The facilities policy and procedure on incident management were implemented. 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.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence:
There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of RN's are current. The service also maintains copies of other visiting practitioner's certification including GP,

pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions and training. There is an annual appraisal process in place and appraisals are current in all files reviewed. This is an improvement since the previous audit.
There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in five of seven files reviewed. This is an area requiring improvement. Interviews with seven caregivers (five rest home and two hospital) described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the quality control coordinator and the clinical coordinator. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. The quality control coordinator and clinical coordinator are accountable for managing and delivering the training schedule. Interview with seven caregivers inform there is access to sufficient training. Medication competencies are completed for all RNs and staff who administer medication. These are checked by the quality control coordinator or clinical coordinator.

D17.7d: There are implemented competencies for RNs related to specialised procedure or treatment including (but not limited to); medication and syringe driver use.

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 is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in five of seven files reviewed. Interviews with seven caregivers (five rest home and two hospital) described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the quality control coordinator and the clinical coordinator.
Finding: Two of seven staff files sampled, do not contain orientation records.
Corrective Action: Ensure that all new staff complete an orientation and that a record of this is maintained.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA
Evidence: The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the clinical coordinator or quality control coordinator will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents.

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

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

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

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

Attainment and Risk: FA

Evidence:

D.16.2, 3, 4: All five files (two rest home and three hospital) reviewed identified that the registered nurses (RN) complete an initial assessment within 24 hours. Information gathered on admission provide the basis for the initial assessment and initial support care plan. All five files sampled identified that the long-term care plan is developed within three weeks.
Sampled files show that there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is conducted within stated timeframes. The services are coordinated to promote continuity of service delivery. Staff (seven caregivers- five rest home and two hospital and one RN) interviews confirm residents and/or family members are involved in all stages of service provision.
Six of six resident interviews (three from each area) confirm their input into assessment, care planning, care plan evaluations and multidisciplinary reviews, except one resident who has been admitted recently and a multidisciplinary review has not been required as yet.
Staff competency assessments are current and staff training programs are implemented. The care plan audit was last conducted in February 2014 and no corrective actions were required.
The rest home and the hospital clinical coordinators are both experienced RNs in care of the elderly. They both have access to external training and support. Staffing levels and staff mix is appropriate for the service level. Documented hand-overs between shifts are sighted and staff interviews confirm verbal briefing between shifts occurs.
D16.5e: Five files sampled identified that the GP had seen the resident within two working days. Resident's GP had examined the resident at least three monthly and carried out a medication review. Three monthly GP exemption is noted in the first page of the clinical notes.

Tracer Methodology. Hospital

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

Tracer Methodology. Rest home.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

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

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

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

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA
Evidence: Residents' care plans are completed by the clinical coordinator in the rest home and the RNs and the clinical coordinator in the hospital in conjunction with inputs from caregivers, residents and family members. Five files (three hospital and two rest home) reviewed showed that the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. Care plan interventions give clear direction to caregivers who provide daily care to residents including the required encouragement, direction, or supervision of a resident. Staff utilise written progress notes to record any current issues. The GP documentation and records are current. There are adequate equipment and supplies to provide services and staff interview confirm this. Service delivery is recorded and evaluated by staff or the RN each shift or more often if anything out of the ordinary occurs. When a resident's condition alters, clinical coordinators or the RN initiates a review and if required, GP or specialist consultation. Six residents interviewed (three hospital and three rest home) are complimentary of care received at the facility. Family interviews (one rest home and three hospital) confirm satisfaction with the services provided for their relatives. Staff are observed considerate of residents' needs on the day of audit. D18.3 and 4 Dressing supplies are available and 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. There are two wounds in the rest home wounds- one is healing and the second is a new wound. One hospital resident has two surgical wounds. The GP is closely monitoring both of them. All wounds have an assessment completed and a management plan. Specialist continence advice is available as needed and this could be described. Continence management in-service has been provided. The RN and clinical coordinators interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: The activities officer works 30 hours a week across rest home and hospital. She was on leave on the day of audit. There is a monthly activities program that is appropriate to the functional capabilities of residents. Residents are able to participate in indoor and external activities and this is facilitated by using the Van or with assistance by families for transport. There are also visits from community groups. Residents are able to provide feedback and suggestions for activities and the resident interview confirmed that these are considered and stated that they enjoyed the activities provided. All five residents' files reviewed show that the individual activities assessments identify residents past interests and leisure and recreation preferences. Activities coordinator is involved as a member of multidisciplinary team in reviewing the activities program regularly.

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: D16.4a Care plans are evaluated by the RNs or the clinical coordinators at least six monthly or when changes to care occur. Five out of five resident' files sampled showed individual, consumer-focused evaluations that indicate progress towards meeting goals. Audits of resident's records were conducted in 2013 and February 2014 including care plans, continence management and wound care management and all show full compliance. Six residents (three rest home and three hospital) interviewed, all confirm that staff review their care and treatment with them. There is documented evidence of additional input from professionals or specialists if this is required. Resident files reviewed included referral letters to the palliative care services, oncology department of the local DHB, psychogeriatrician, nurse specialists and Nurse Maude. Multidisciplinary reviews are current. Seven caregivers and one RN interviewed confirm processes are implemented and documented in the residents' care plans when a resident's condition changes. Review of medical notes shows GP notification following an acute event and required interventions are documented and implemented.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

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

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)
Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

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

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)
Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

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

Attainment and Risk: PA Moderate
Evidence: Kaiapoi Lodge uses monthly medico packs. In the hospital, medications are stored in the locked treatment room. In the rest home, the drug room is not locked but all cabinets are locked. The medication trolley is locked and secured with a key lock attached to the ceiling via a metal cord. Controlled drugs are stored in a locked cabinet inside a locked cupboard in the medicine storeroom in the rest home and the treatment room in the hospital. Medication reconciliation occurs on arrival for new residents. Medicines requiring refrigeration are kept in the fridge in the kitchen in a container. Stock medicines are checked for expiry dates and expired medicines are sent to the pharmacy with the exception of a controlled drug. There are no standing orders authorised by GPs. Controlled drugs register is maintained and shows weekly checks by the RNs and clinical coordinators. There are three residents who receive controlled drugs in the hospital and three residents in the rest home. Administration of these controlled drugs are found to be correct, however the audit identified an improvement required around management of controlled drugs. Policies and procedures clearly identify the responsibility, accountability and scope of practice of staff and residents during medicine management. RNs in hospital wing and medicine competent caregivers in the rest home administer medicines. Staff education programme includes medication training and this was conducted in April 2013. Staff interviewed confirm they have received on-going training in medication management and that their medication competency assessments are current. Competencies are sighted in the staff files. Registered nurses maintain Niki T syringe driver competencies. Policies and procedures are in place for residents who wish to self-administer medicines. The RN and the rest home clinical coordinator stated there are no residents who self-administer medicines at the facility, on the day of audit. Eighteen (ten hospital and eight rest home) medicine charts reviewed. All medicine charts sampled demonstrate documentation is legible. PRN medication is clearly identified for individual residents and administered as charted. Residents (six) and families (four) interviewed stated they are kept informed of any changes to medications. Resident' medications are reviewed by the

residents' general practitioner at least three monthly. Medication audit is last completed in December 2013 and shows full compliance.

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: Kaiapoi Lodge uses monthly medico packs. In the hospital, medications are stored in the locked treatment room. In the rest home, the drug room is not locked but all cabinets are locked. The medication trolley is locked and secured with a key lock attached to the ceiling via a metal cord. Controlled drugs are stored in a locked cabinet inside a locked cupboard in the medicine storeroom in the rest home and the treatment room in the hospital. Medication reconciliation occurs on arrival for new residents. Medicines requiring refrigeration are kept in the fridge in the kitchen in a container. Stock medicines are checked for expiry dates and expired medicines are sent to the pharmacy with the exception of a controlled drug. There are no standing orders authorised by GPs. Controlled drugs register is maintained and shows weekly checks by the RNs and clinical coordinators. There are three residents who receive control drugs in the hospital and three residents in the rest home. Administration of these control drugs are found to be correct, however the audit identified an improvement required around management of controlled drugs.
Finding: The audit identified issues around management of controlled drugs. 1) A controlled drug issued in 11 June 2012 and advised that the resident brought the controlled drug (Morphine LA) to the facility on the day of admission and it was registered in the controlled drug book. The medication expired in September 2013. The controlled drug was not administered and not charted in the resident's drug chart by the GP. 2) Six monthly physical stock takes of controlled drugs is not completed.
Corrective Action: Ensure that physical stock takes of controlled drugs is completed at least six monthly and expired medications are returned to the pharmacy.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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

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

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

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

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

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

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA
Evidence: The food is cooked on site and delivered to the two dining rooms and served from bain-maries. There are currently four kitchen staff including two cooks and two kitchen assistants. Standardized menus are planned on a six weekly rotating cycle to allow variation. Menus are reviewed annually. The menu range is varied and appropriate to the resident group. A complete suite of policies related to management of food service and special food needs of elderly is available to staff. Resident's weight is monitored. Personal preferences/likes/dislikes are noted on admission in the resident's file and the kitchen is advised. Changes to residents' dietary needs are communicated to the Kitchen and modified foods are provided such as soft diet, pureed diet and diabetic diet. It is the RN's responsibility to detail dietary requirements of each resident in their food and nutrition form and the care plan. All five files reviewed (two rest home and three hospital) have residents' current dietary needs recorded and a copy is also kept in the kitchen. . A visual inspection of the kitchen evidences compliance against all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal. Food temperature recordings and fridge / freezer temperature recordings are sighted. Six out of six residents interviewed (three rest home and three hospital) confirm they enjoy their meals and that adequate food and fluids are provided. Staff interview (five rest home and two hospital caregivers) confirm training around food safety and knowledge around resident's current dietary needs. Auditors observed that residents who require one to one assistance, it is provided at meal times.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires 30 June 2014. Electrical equipment is checked. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are handrails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas. Hoists are serviced annually and medical equipment is calibrated annually. ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)
Consumers are provided with safe and accessible external areas that meet their needs.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)
Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence:
There is a restraint policy and manual with associated procedures and templates. The policy states that the use of restraints is kept to a minimum and that care staff who may be involved in restraint and enabler use have sufficient knowledge and skill to be able to ensure resident safety.

The restraint policy and procedure includes definitions such as use of restraint, types of restraint permitted, use of enablers, enablers permitted, client rights, assessment, discussion, restraint alternatives, monitoring and removal. There is a restraint/enabler assessment form, consent form and monitoring form.
Kaiapoi Lodge has four residents with restraints. The restraint policy requires that the service considers alternatives to restraint prior to any intervention. The policy also includes procedures for the use of restraint, cultural considerations, guidelines for restraint use and monitoring. On-going consultation with the resident and family/whanau is also identified.
The service identifies enablers as items, which are voluntarily used for safety. There are no residents who use enablers currently at Kaiapoi Lodge.
The restraints policy defines enablers as being voluntary use of equipment e.g. for safety for the resident. All seven caregivers (five rest home and two hospital) interviewed could describe processes around enabler, restraint and challenging behaviour practice.
The service has clear documentation to guide staff in the use of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

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

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

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: Infection monitoring is the responsibility of the infection control coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents. The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff and three monthly quality assurance meetings (minutes viewed). The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Internal audit of infection control is included in the annual programme and occurs six monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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

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