Tainui Home Trust Board

Current Status: 11 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

Tainui Rest Home provides care for 58 residents who require rest home and hospital level care on the day of this audit. The facility is operated by Tainui Home Trust Board. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. Residents and family interviewed report that the care provided is very good.

The service provider has made some progress towards addressing the areas requiring improvement from the last audit. There are five areas that still require improvement and four new areas identified during this audit that require improvement. These relate to the amount of detail in the complaints register, corrective actions and review of effectiveness of quality improvement data, maintenance of the staff education programme, the currency of staff performance appraisals, maintenance of resident documentation, the safe management of medication, maintaining records of fridge and freezer temperatures and maintaining the restraint register.

Audit Summary as at 11 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

Indicator	Description	Definition
	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 11 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 11 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 medium or high risk and/or unattained and of low risk.

Continuum of Service Delivery as at 11 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 11 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 11 March 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

Infection Prevention and Control as at 11 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:	Tainui Home Trust Board
Certificate name:	Tainui Home Trust Board

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Surveillance Audit			
Premises audited:	Tainui Resthome			
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	11 March 2014	**End date:**	11 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:	58

Audit Team

Lead Auditor	XXXXX	**Hours on site**	10.5	**Hours off site**	5.5
Other Auditors	XXXXX	**Total hours on site**	10.5	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	21	Total audit hours off site	12.5	Total audit hours	33.5

Number of residents interviewed	4	Number of staff interviewed	15	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	88	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) 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 Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Monday, 24 March 2014

Executive Summary of Audit

General Overview
Tainui Rest Home provides care for up to 58 residents who require rest home and hospital level care, and there are 58 residents on the day of this audit. The facility is operated by Tainui Home Trust Board. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. Residents and family interviewed report that the care provided is very good. The service provider has made some progress towards addressing the areas requiring improvement from the last audit. There are five areas that still require improvement and four new areas identified during this audit that require improvement. These relate to the amount of detail in the complaints register, corrective actions and review of effectiveness of quality improvement data, maintenance of the staff education programme, the currency of staff performance appraisals, maintenance of resident documentation, the safe management of medication, maintaining records of fridge and freezer temperatures and maintaining the restraint register.

Outcome 1.1: Consumer Rights
The service provides an environment conducive to effective communication. Residents and family members interviewed report that services are provided in a manner that respects residents' rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms. The Quality Assurance Co-ordinator is responsible for management of complaints. There have been two internal complaints since the last audit. There have been no investigations by external agencies. There is an area requiring improvement relating to the complaints register not providing sufficient detail.

Outcome 1.2: Organisational Management
Tainui Home Trust Board is the governing body and is responsible for the service provided at Tainui Rest Home. Planning documents reviewed include a business plan, a quality improvement plan as well as a philosophy of care and core values for the service. Systems are in place for monitoring the service provided at Tainui Rest Home, including regular monthly reporting to the governing board. Reporting also occurs via various staff meetings. The facility is managed by a suitably experienced chief excective officer (CEO) who is a registered nurse and has been in this position since February 2013. The CEO/manager is supported by a clinical manager / registered nurse (RN) who has been in this position since June 2013. The clinical manager is responsible for the oversight of clinical care in the facility. There is evidence that quality improvement data is being collected, collated and analysed to identify trends and this information is reported to the governing body and to staff. There is an internal audit programme in place. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. The area requiring improvement from the last audit relating to quality policies not being updated to reflect changes to management, accountablilities and related systems has been addressed. The area relating to corrective actions not always reviewed for effectiveness remains an area for improvement and this audit identifies corrective actions are not always developed following identified deficets.

The area requiring improvement from the last audit relating to post event follow up documented on incident/accident forms has been addressed, however, a new area is identified relating to incident/accident forms are not always completed following residents' experiencing adverse events.
There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RNs), pharmacists, physiotherapist, dietitian, and general practitioners (GPs) is occurring.
Staff are supported to complete Careerforce education and 'Care Training on Line'. Review of staff records provides evidence of human resources processes being followed and individual education records are maintained. The area identified at the last audit relating to staff appraisals not completed for all staff and staff training not maintained as per the programme remains areas requiring improvement.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse, one enrolled nurse and one caregiver.
The clinical manager/RN, and an RN share the after hours on call. The CEO/manager is on call for non-clinical issues after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

Outcome 1.3: Continuum of Service Delivery

Care and support is provided by a range of health professionals, including external allied health providers. Time frames for service provision are defined and monitored and care plans sampled provide evidence of good nursing practice; however four areas requiring improvement are identified. These include ensuring that all care plans are signed off by a registered nurse, ensuring all care plans include and required interventions and have been updated as required. The medicine management system also requires a number of improvements.
Activities are planned to meet the needs of the resident. Individual activity goals are documented and ensure the provision of relevant and appropriate activities are provided. Previous interests, hobbies, culture and ability is considered. Sufficient activities and outings are provided and participation in activities is voluntary.
Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation meets good hygiene practice; however the provider is required to ensure that records of fridge and freezer temperatures are maintained.

Outcome 1.4: Safe and Appropriate Environment

The building has a current warrant of fitness. There have been no alterations to the building since the last audit.
The area requiring improvement from the last audit relating to records of required maintenance checks not being maintained has been addressed.

Outcome 2: Restraint Minimisation and Safe Practice

There are adequately documented guidelines on the use of restraints and enablers. Alternatives to restraint are effectively in use. There is currently one resident with a chair restraint in place and this is being used safely, however the consent and restraint register requires updating to reflect same.
All staff receive sufficient training on restraint and enabler use.

Outcome 3: Infection Prevention and Control

The organisation carries out surveillance that is appropriate to the size and complexity of the service.
The results of surveillance are used in assisting infection prevention and reduction. Findings are collected, evaluated and reported to management on a

monthly basis.
The infection control programme is clearly documented and is suitable for a hospital/rest home setting. The infection surveillance program is appropriate for the facility and the level of care provided. Infection data is analysed for trends and communicated to staff. The use of antibiotics is monitored. There have been no infection issues or out breaks since the last audit.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	10	0	8	1	1	0
Criteria	0	32	0	6	4	1	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	30
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	The complaints register does not allow for sufficient information to be recorded concerning the investigation, management response, and action taken.	Provide evidence that a complaints register is developed and implemented to allow for sufficient detail to be recorded.	90
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and risk management system that reflects continuous quality improvement principles.				
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Not all completed audits have corrective actions developed and where corrective actions have been documented, the effectiveness of the corrective action has not been reviewed.	Provide evidence that when deficits are identified, corrective actions are competed, and reviewed for effectiveness.	90
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incident/accident forms are not always completed following unplanned or untoward events.	Provide evidence that incident/accident forms are completed following all unplanned or untoward events.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		accordance with good employment practice and meet the requirements of legislation.				
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The 2014 education programme is currently being revised to include all training requirements, and review of staff files shows staff have not attended many education sessions.	Provide evidence that an education programme is developed and staff attend education sessions, and receive at least 8 hours training over the 12 month period.	90
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.1	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.	PA Low	Not all care plans sampled have been signed off by a registered nurse as required.	Provide evidence that all care plans are signed off by a registered nurse.	60
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	The previous area of improvement regarding multidisciplinary reviews has not been sufficiently addressed. Although there is a weekly review of residents ‘of concern’, this does not constitute an	Conduct multidisciplinary reviews as required.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				evaluation/multidisciplinary review.		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Not all care plans/intervention have been developed/updated as and when required.	Provide evidence that all care plans are sufficiently documented, consistent with current needs and include the required interventions.	30
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 High			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	Implementation of the medicine management system does not meet legislative requirements, guidelines or best practice.	Provide evidence that the medicine management system meets legislative requirements, guidelines or best practice	1
HDS(C)S.2008	Standard 1.3.13:	A consumer's	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Nutrition, Safe Food, And Fluid Management	individual food, fluids and nutritional needs are met where this service is a component of service delivery.				
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Records of fridge and freezer temperatures have not been maintained.	Keep records of fridge and freezer temperatures	60
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 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.	PA Low	The restraint consent has not been updated to reflect the current type of restraint in use. This has also not been added to the restraint register.	Update the restraint consent and register.	30
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.3.5	A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.	PA Low	The restraint consent has not been updated to reflect the current type of restraint in use. This has also not been added to the restraint register	Update the restraint consent and register.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Open disclosure procedures are in place to ensure staff maintains open, transparent communication with residents and their families. Residents' files reviewed (three hospital and two rest home) provide evidence that communication with family is being documented in residents' files in family communication sheets. On admission the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about, as well as what time of day they wish to be notified for any discussion. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.

Four residents and three family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The quality assurance co-ordinator, and clinical manager/registered nurse (RN) advise access to interpreter services is available if required via advocacy services, the chaplain and age concern. Staff members interviewed advise they currently have no residents who require interpreters.

Staff are identifiable by their name badge and uniforms (observed). Staff introduce themselves to residents upon entering the resident's room (observed).

The ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA	
Evidence:	
Finding:	
Corrective Action:	
Timeframe (days):	*(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: PA Low
Evidence:
Complaint information is included in the resident information booklet and residents and family members interviewed report they are aware of their right to complain. Staff are informed of the complaints procedure during their initial orientation. A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of meeting minutes provides evidence of reporting on complaints. The quality assurance co-ordinator reports that there have been no complaints to the Health and Disability Commissioner or the District Health Board since the last audit. There are two documented complaints since the last audit and include verbal concerns which have been expressed by staff, residents or family. The complaints register is sighted and is included in the incident/accident register. There is an area requiring improvement relating to insufficient detail recorded concerning the investigation, management response, and action taken. (See criterion 1.1.13.3.)

ARC requirements are not fully met.

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: The complaints register is reviewed and is included as part of the incident/accident register. The register is up to date and has two complaints recorded since the last audit. Documentation sighted provides evidence that the complaints are managed appropriately. The complaints register does not allow for sufficient information to be recorded concerning the investigation, management response, and action taken.
Finding: The complaints register does not allow for sufficient information to be recorded concerning the investigation, management response, and action taken.
Corrective Action: Provide evidence that a complaints register is developed and implemented to allow for sufficient detail to be recorded.
Timeframe (days): 90 *(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: Tainui Home Trust Board is a charitable trust. The trust board manual and quality manual defines the scope of the service. Strategic goals for the year are documented and an organisational chart is sighted, and is current. Organisational performance is formally monitored through monthly board reporting. Regular management meetings, policy meetings, and finance committee meetings are conducted. Board reports are reviewed and include detailed financial reports from the business manager, reports on trends and clinical indicators from the clinical manager and the CEO/manager management report. The CEO/manager is responsible for the day to day operations and overall management. The CEO has been in this position since February 2013. The CEO/manager has a BA (Hons) in nursing, a master's degree in business and a diploma in management systems. The CEO/manager has completed the ACC partnership injury management training (Dec 2012), Healthcare Help Manager Training and Networking (July 2012) and attended a Managers Combined Midland's/Northern Forum (June 2012). This year the CEO/manager has completed a course on Human Resource Systems, Working with Governing Boards and Risk Management. The clinical manager has been in this position since June 2013. Interview of the clinical manager and review of their personal file provides evidence the clinical manager is a suitably qualified registered nurse who has experience in the area of geriatric assessment, and general medical nursing. ARC requirements are met.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

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

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

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

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: PA Low
Evidence: The area requiring improvement from the last audit relating to policies not reflecting the current management structure and changes is now fully attained. The quality manual and policies have been reviewed and updated to reflect changes in management structure. The quality and risk management plan which has recently been reviewed is used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A Health and Safety manual is available that includes relevant policies and procedures. Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. There is documented evidence quality improvement data is being collected, collated and analysed including reporting on numbers of various clinical indicators and quality and risk issues to staff. Quality improvement data reviewed, including internal audits, and improvements are required as corrective actions are not always developed following deficits being identified and effectiveness is not always reviewed following corrective actions. Corrective actions not reviewed for effectiveness was identified at the last audit and remains open. (See criterion 1.2.3.8). Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. There are various meeting held including staff/infection control, health and safety, RN/EN, restraint. There is documented evidence of reporting on

numbers of various clinical indicators and quality and risk issues in the staff meetings. Copies of meeting minutes and clinical indicators are displayed for staff to review.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service reflects current accepted good practice, and reference legislative requirements. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies/revised policies in the staff room, via handover, and via meetings.

Not all the ARC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)
Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

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

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)
A process to measure achievement against the quality and risk management plan is implemented.

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

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)
A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: PA Moderate
Evidence: Various meeting minutes are reviewed including RN/EN, restaint, general staff/infection control , and care givers, and corrective actions are developed and impemented. However, not all internal audits sighted have corrective actions plans documented. Improvement is required relating to developing corrective actions deficits identified following completion of internal audits and all corrective actions have been reviewed for effectiveness.

Finding: Not all completed audits have corrective actions developed and where corrective actions have been documented, the effectiveness of the corrective action has not been reviewed.
Corrective Action: Provide evidence that when deficits are identified, corrective actions are competed, and reviewed for effectiveness.
Timeframe (days): 90 *(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: PA Low
Evidence: The adverse event reporting system provides evidence of a planned and co-ordinated process. Adverse, unplanned or untoward events are recorded on an accident/incident form, sighted, which are then reviewed by the quality assurance co-ordinator, who reviews these forms and follows up as required. Once the accident/incident form is completed it is entered on to an incident/accident register for collation.

The area requiring improvement identified at the last audit has been addressed. A neurological observation form has been developed and implemented to record observations following post events occurring. However, there is a further improvement required as one rest home resident experienced an incident and there is no evidence of an incident/accident form completed. Another resident's medication chart has a different dose recorded to that in the resident's blister pack; no incident/accident was completed. (See criterion 1.2.4.3). Original accident/incident forms are retained in the resident's files, and a copy kept in a file. 2013 and 2014 data reviewed includes summaries and registers of various clinical indicators including falls, medication errors, skin tears, and behaviour.

There is an open disclosure policy. Resident files reviewed (five) provide evidence of communication with families following adverse events involving the resident, or any change in the residents condition.

Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions and policies and procedures. Policies and procedures comply with essential notification reporting e.g. health and safety, human resources, infection control.

Not all ARC requirements are met.

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence:
Adverse, unplanned or untoward events are recorded on an accident/incident form, sighted, which are then reviewed by the quality assurance co-

ordinator, who reviews these forms and follows up as required. Once the accident/incident form is completed it is entered on to an incident/accident register for collation. However, there is improvement required as one resident rest home experienced an incident and there is no evidence of an incident/accident form completed. Another resident's medication chart has a different dose recorded to that in the resident's blister pack; no incident/accident was completed.

Finding:

Incident/accident forms are not always completed following unplanned or untoward events.

Corrective Action:

Provide evidence that incident/accident forms are completed following all unplanned or untoward events.

Timeframe (days): 90 *(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 Moderate

Evidence:

Written policies and procedures in relation to human resource management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (10) along with employment agreements, reference checking, completed orientations and competency assessments (as appropriate). Current practising certificates are sighted for RNs, ENs, pharmacist, physiotherapist, and the 17 GPs that visit the facility.
An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to seven duties to complete and staff performance is reviewed at the end of this period. The quality assurance co-ordinator advises the timeframe for completing the orientation is for review with a view to extend to three month foe completion. Orientation for staff covers the essential components of the service provided i.e.: the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy.

The human resource management system provides for the implementation of processes both at the commencement of employment and on-going in relation to staff education. Careerforce and 'Care Training on Line' education is provided and staff are supported to complete these education programmes. The clinical manager is interviewed and reports the education programme for 2014 is currently being reviewed and is partly developed to include all ongoing education required to meet the requirements of the 'Health and Disability Sector Standards' and the DHB Contract, sighted. Review of education records and individual records of education (10) are maintained for each staff member, however, apart from education on infection control and restraint minimisation and the associated competencies, there is not much evidence of other required ongoing education attended by staff during 2013 and 2014, and it is difficult to evidence that staff have received eight hours of training in the last 12 months. This is an area that requires improvement, and was identified at the last audit. (See criterion 1.2.7.5.).

An appraisal schedule is in place, however, not all performance appraisals are current, and some have not been completed since 2009 and 2011. This was an area identified at the last audit and is still an area requiring improvement. (See criterion 1.2.7.5).

Not all the ARC requirements are met.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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

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

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

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

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

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

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

Attainment and Risk: PA Moderate
Evidence: The human resource management system provides for the implementation of processes both at the commencement of employment and on-going in relation to staff education. Careerforce and 'Care Training on Line' education is provided and staff are supported to complete these education programmes. The clinical manager is interviewed and reports the education programme for 2014 is currently being reviewed and is partly developed to include all ongoing education required to meet the requirements of the 'Health and Disability Sector Standards' and the DHB Contract, sighted. The quality assurance co-ordinator reports they are reviewing the way the education programme is implemented as staff are not attending sessions. Review of education records and individual records of education (10) are maintained for each staff member, however, apart from education on infection control and restraint minimisation and the associated competencies, there is not much evidence of other required ongoing education (including medication competencies) attended by staff during 2013 and 2014, and it is difficult to evidence that staff have received eight hours of training in the last 12 months. This is an area that requires improvement, and was identified at the last audit. An appraisal schedule is in place, however, not all performance appraisals are current, and some have not been completed since 2009 and 2011. This was an area identified at the last audit and is still an area requiring improvement.
Finding: The 2014 education programme is currently being revised to include all training requirements, and review of staff files shows staff have not attended many education sessions.
Corrective Action: Provide evidence that an education programme is developed and staff attend education sessions, and receive at least 8 hours training over the 12 month period.
Timeframe (days): 90 *(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: There is a clearly documented staffing rationale, 'Staffing Levels/Mix Policy' is sighted for determining service provider levels and skill mixes in order to provide safe service delivery in place at Tainui rest home that is based on best practice. The roster is reviewed and the minimum amount of staff is provided during the night shift and consists of one RN, one EN, and one care giver. The clinical manager/RN, and a RN share the after hours on call. The CEO/manager is on call for non-clinical issues after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work. Residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirm adequate staff cover is provided. The ARC requirements are met.

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

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

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Assessments and care plans are required to be developed and reviewed by a registered nurse with a current practicing certificate (as per the District Health Board contract). At Tainui, the enrolled nurses are considered suitably qualified to complete care plans; however these are required to be signed off by a registered nurse. One of the care plans sampled and written by an enrolled nurse had not been signed off by the registered nurse and an improvement is required.

Daily interventions and support with activities of daily living are implemented with the help of trained care givers and allied health providers. Continuity of care is maintained and residents' files sampled evidence multidisciplinary involvement. Daily handovers ensure day to day continuity. A handover is observed and confirms relevant and appropriate information sharing about residents' needs. A visiting occupational therapist is interviewed during the audit and confirms that the staff at Tainui effectively implement the suggested interventions. This is also confirmed by the General Practitioner (GP) interviewed.

Timeframes for service delivery are defined and met as evident in the 10 residents' files sampled (three hospital residents and two rest home residents). An initial nursing assessment/short term plan is performed on admission and a medical assessment conducted by the GP within forty eight hours. An admission checklist is used to ensure timeframes are met. Following this the care plan is developed and implemented to meet the identified needs and goals of the resident. Short term care plans are also developed in the event of short term needs, for example wounds or infections.

Care plans are reviewed every three months. Registered nurses/enrolled nurses case manage care plan reviews. The required three monthly reviews are sighted in files sampled and have been conducted within the defined timeframes; however there was a previous area of improvement regarding multidisciplinary reviews and this is yet to be sufficiently addressed. The newly implemented process of weekly 'reviews' for all residents who have identified issues does not constitute an evaluation.

The remaining District Health Board contract requirements have been met. For example, residents are assessed by their GP on entry, responsibilities for the provision of daily care is identified during the handover report and care plans include the required domains.

Hospital resident file sampled using tracer methodology:

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

Rest home file sampled using tracer methodology:

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

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

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

Attainment and Risk: PA Low
Evidence: 10 care plans are included in the sample. One of these has been developed by an enrolled nurse and has not been signed off by a registered nurse.
Finding: Not all care plans sampled have been signed off by a registered nurse as required.
Corrective Action: Provide evidence that all care plans are signed off by a registered nurse.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.3 (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: PA Low
Evidence: Care plans sampled provide sufficient evidence of three monthly reviews; however the multidisciplinary review process is yet to be sufficiently implemented. The Clinical Manager has recently commenced weekly team meetings which include discussions of all residents 'of concern' (confirmed). This initiative is enabling effective risk management (at a service delivery level); however it does not meet the requirements of a multidisciplinary review/evaluation of care.
Finding: The previous area of improvement regarding multidisciplinary reviews has not been sufficiently addressed. Although there is a weekly review of residents 'of concern', this does not constitute an evaluation/multidisciplinary review.
Corrective Action: Conduct multidisciplinary reviews as required.
Timeframe (days): 90 *(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

Attainment and Risk: FA
Evidence: The previous area of improvement regarding post evident observations and risk has been adequately 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.

Attainment and Risk: FA
Evidence: There are sufficient records of observations following events such as unwitnessed falls and choking. Risk assessments are also updated as required .
Finding:
Corrective Action:

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

Standard 1.3.5: 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

Attainment and Risk: FA
Evidence: The previous area of improvement regarding monitoring and management of residents with weight loss has been adequately 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.

Attainment and Risk: FA	
Evidence: Records of regular weight monitoring is sighted in files sampled and included in care plans (where required).	
Finding:	
Corrective Action:	
Timeframe (days):	*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Low
Evidence: The care plan includes concerns/problems, nursing goals and resident goals. Interventions are documented for hygiene, oral hygiene, dressing, elimination, mobility, skin care, behaviour/communication, hearing, vision, special night needs, nutrition, fluids, weight, spirituality, sexuality, cultural needs, falls risk, pressure area and pain. Level of dependence is documented. Interventions are then documented and address each domain/goal or identified problem.

The required care plans/interventions are not sighted in three out of 10 resident records sampled and an improvement is required.

Interventions sighted address the assessed needs and goals and are consistent with the nursing process. The GP interviewed is satisfied that clinical interventions are implemented in a timely and competent manner. Staff were observed making appropriate and timely phone calls the GP on the day of the audit. Interventions from allied health providers are also given due consideration. For example the Mental Health of the Older Person occupational therapist progress notes for a confused resident are cross referenced in the nursing progress notes.

Short term care plans redeveloped as required and these are consistently sighted in files sampled.

The District Health Board contract requirements have been met.

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

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

Attainment and Risk: PA Moderate
Evidence: The care plan for one resident who XXXXX has not been updated to include the requirement for food to be soft/moulied. The care plan of a hospital resident who has developed XXXXX has not been updated to reflect same. The resident has had the wound since September 2013 and the care plan was last updated in January 2014 with no mention of the wound. The XXXXX assessment (from where the wound originated) has also not been updated since July 2013. One resident with XXXXX does not have a sufficiently documented behaviour plan which includes precedents and interventions (although it is noted that staff are managing this resident very well and a disruptive behaviour checklist is documented). Family and allied health providers are also involved (confirmed).
Finding: Not all care plans/intervention have been developed/updated as and when required.
Corrective Action: Provide evidence that all care plans are sufficiently documented, consistent with current needs and include the required interventions.
Timeframe (days): 30 *(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 activity programme is developed and coordinated by the two Diversional Therapists (DT's) who are both on site five days per week (32.5 hours) and maintain the programme in the absence of the other. The current activities plan is sighted and provides a sufficient range of planned activities to develop and maintain strengths and interests. Regular exercises and outings are provided for those able to partake. Activities support independence and reflect normal daily living. For example shopping, ironing, cooking etc. On admission a Diversional Therapist checklist is completed. Family and residents are given a 'this is your life' form to complete and a likes and dislikes checklist. These are reviewed the DT following admission and a DT lifestyle plan is developed. The plans are reviewed monthly with a six month evaluation. Records sighted confirm the system is implemented and modifications made as required. Individual attendance records are maintained. These include a brief summary on monthly responses to activities. Satisfaction with the programme is included in resident meetings (monthly) and a recreational programme survey is conducted. Records of residents meetings are sighted and confirm satisfaction with the programme. Residents interviewed report that attendance at activities is encouraged but participation is voluntary. The District Health Board contract requirement are met.

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

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

Attainment and Risk: FA
Evidence:
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: Care plan reviews are conducted every three months by the registered nurses with input from the resident, family, staff, and diversional therapists. Family are notified of any changes in resident's condition and this is evident in resident files sampled. Residents and family interviews confirm their participation in the care plan review process. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if required. Wound and infection care plans are evaluated as and when required. Three monthly GP reviews are also evident in resident files sampled. Opportunities for improvement are documented in criterion 1.3.3.4 regarding multidisciplinary reviews and criterion 1.3.6.1 regarding updating care plans as required. The District Health Board contract requirements are met

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 High
Evidence: There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements, however a number of improvements to the medication system are required. These include improvements to prescribing practices, storage of medicines, medication errors and preparation/administration practices. The Blister Pack medication system is used and three monthly medication reviews are evident in medication files sampled. Medications are stored securely in the nurses' stations and the previous improvement regarding the temperature of the nurses' station has been adequately addressed. Medications are administered by the registered nurses, enrolled nurses and senior caregivers. Competencies for medication management are assessed, however no ongoing training has occurred and an improvement is documented in criterion 1.2.7.5. The mid-day medication round is observed and both staff are observed as competent. The District Health Board contract requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes medication reconciliation and is sighted in GP records sampled.

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 High

Evidence:

Standing Orders have not been updated to include the 2012 Guidelines.
Not all medications have been returned to the pharmacy and (some) are being used as stock (codeine phosphate, buscopan and Vitamin B12).
Medication charts are being pre-written (transcribed) by a staff member and then signed when the GP visits. Two out of 10 medication charts sighted having not GP signature. Non signed medication charts included paracetamol, laxsol and lactulose.
There is no evidence (on two medication charts sampled) that changes to scripts have been authorised by the prescriber.
Four out of 10 medication charts sampled did not have allergies recorded.
Not all controlled drugs are stored safely For example codeine phosphate was found in the medication trolley and not locked in the controlled drug cupboard.
Morning nurses are dispensing medicines (warfarin) into named (but unlabelled) bottles for administration by afternoon staff.
Pharmacy stock check of controlled drugs has not been completed six monthly as required (last check May 2013). This was a previous opportunity for improvement.
Specimen signatures have not been maintained for all the visiting GP's.
Two bottles of opened eye drops were still in the medication system having been opened for more than 30 days.
One medication chart sampled reflects a different dose to what is in the blister pack. One tablet is prescribed (on the medication chart) and two are in the blister pack. It was unclear whether the resident was being administered one or two. This was identified by a staff member in January 2014, however no medication error is recorded (refer 1.2.4.3) and the error has continued.
One administration record sampled had a gap (lunch time dose of furosemide) with no related explanation in the progress notes or administration chart.
The medication fridge temperature on the day of the audit was minus zero degrees and was reported as zero degrees when last recorded over a week ago. No corrective action was evident.
The administration record of one resident had medication administered with no associated prescription. The standing orders from the residents GP was last signed in December 2012.

Finding:

Implementation of the medicine management system does not meet legislative requirements, guidelines or best practice.

Corrective Action:

Provide evidence that the medicine management system meets legislative requirements, guidelines or best practice

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)
The facilitation of safe self-administration of medicines by consumers where appropriate.

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)
Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

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

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)
A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

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

Attainment and Risk: PA Low
Evidence:
The nutritional needs of residents are met. The residents' nutritional status, including likes and dislikes, is assessed on admission and needs identified. Level of assistance required is also recorded. The menu plans are conducive for residents in an aged care residential setting and have been reviewed by a

dietician to ensure appropriateness.

The kitchen is tidy and well maintained, however temperature records for the fridge and freezer have not been consistently maintained.

Satisfaction surveys sighted confirm general satisfaction with the food. The cook interviewed is aware of likes and dislikes and provides alternatives if required. Records of any deviation from the menu are maintained in a communication book. Fluids and snacks are readily available.

The District Health Board contract requirements are met.

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

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

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

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

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

Attainment and Risk: 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: PA Low
Evidence: Records of fridge and freezer temperatures have not been maintained. There are 10 gaps in the records for the month of February and March 2014.
Finding: Records of fridge and freezer temperatures have not been maintained.
Corrective Action: Keep records of fridge and freezer temperatures
Timeframe (days): 60 *(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: A Building Warrant of Fitness is displayed at the main entrance that expires on 28 February 2015. The area requiring improvement from the last audit under criterion 1.4.2.1 has been addressed. A ‘Schedule of Tasks Proactive Maintainance’ is sighted and is current and provides evidence of sign off by the maintainance person following completion of proactive mainatainance. ARC requirements are met.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)
All buildings, plant, and equipment comply with legislation.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

ARC E4.4a ARHSS D16.6

Attainment and Risk: PA Low
Evidence: Restraint minimisation is promoted by management and alternatives provided where able. The restraint minimisation and safe practice policy includes definitions for enablers and restraint. Staff training on the use of restraints/enablers and alternatives is provided. Nursing staff interviewed report the facility currently has one resident who has a chair restraint in place and this is well managed (with good effect), however the consent has not been updated to reflect the type of restraint in use and the restraint has not been added to the restraint register. An improvement has been documented in criterion 2.2.3.5.

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: PA Low
Evidence: The resident has suffered a number of falls and requires a restraint for safety reasons. A tray table was previously used to discourage the resident from leaving the chair, however this was unsuccessful. A chair restraint is now in place and is working well. The family member is interviewed and confirms consent for the use of the restraint, however the consent form has not been updated and the restraint has not been added to the restraint register.
Finding: The restraint consent has not been updated to reflect the current type of restraint in use. This has also not been added to the restraint register.
Corrective Action: Update the restraint consent and register.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)
Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: The previous improvements required regarding a restraint committee and the key pad being used to secure a resident area has been sufficiently addressed.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)
The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA
Evidence: The key pad into one of the residential areas is no longer in use. The doors remain open and/or unlocked. This is observed on the day of the audit.

The restraint approval group has been established.
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: PA Low
Evidence: The previous area of improvement regarding restraint monitoring and the use of restraint monitoring forms has been adequately addressed; however an additional improvement is required regarding the restraint register.

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA
Evidence: The previous area of improvement regarding restraint monitoring and the use of restraint monitoring forms has been adequately addressed. The required documents are sighted in files sampled.
Finding:

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: PA Low
Evidence: The resident has suffered a number of falls and requires a restraint for safety reasons. A tray table was previously used to discourage the resident from leaving the chair, however this was unsuccessful. A chair restraint is now in place and is working well. The family member is interviewed and confirms consent for the use of the restraint, however the consent form has not been updated and the restraint has not been added to the restraint register.
Finding: The restraint consent has not been updated to reflect the current type of restraint in use. This has also not been added to the restraint register
Corrective Action: Update the restraint consent and register.
Timeframe (days): 90 *(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: The type of surveillance undertaken is appropriate to the size and complexity of the organisation. The infection control Co-ordinator completes a 'Resident Infection Report' with relevant data and collates data monthly into a 'Infection Surveillance Monthly Data Form' that is analysed monthly and a quarterly rate of infection by bed numbers is reported as a clinical indicator to staff at the staff meetings, minutes sighted. Results are also reported to the 'Clinical Liaison Committee' which is part of the trust board. Care staff interviewed report they are made aware of any infections of individual residents by way of

feedback from the RN's, and daily handovers. Audits are completed on a regular basis, sighted.
An appropriate surveillance programme is implemented and suitable to the services provided at the facility. Standard definitions are used to identify infections for surveillance. Infections data is collected and collated monthly and reported at staff meetings. The data is collated to show incidence and trends over time. Review of data records for the last 12 months indicates that infection rates are low with no adverse trends identified.

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.)*