

Mitchell Court (Tauranga) Limited

Current Status: 25 November 2013

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

Mitchell Court provides rest home level care for up to 35 residents. Occupancy on the day of the audit was 26 residents. The facility is privately owned and operated and is part of the Cavell Group. The current operational manager has been employed at Mitchell Court for over two years. A nurse manager who is a registered nurse (RN) supports her. Families and residents interviewed spoke positively of the support provided at Mitchell Court.

Six of the ten shortfalls identified in the previous audit have been addressed. These were around abuse and neglect training, integration of resident files, expired medications, remodelling of the two serviced apartments for rest home use, renovation of two bathrooms and call bells. Improvements continue to be required around timely review of assessments, care planning and review of not for resuscitation orders.

This audit identified further improvements required around first aid trained staff, weight loss management, neurological observations and aspects of medication management.

Audit Summary as at 25 November 2013

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 25 November 2013

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.
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Organisational Management as at 25 November 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 25 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 25 November 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 25 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 25 November 2013

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

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

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

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

Audit Report

Legal entity name:	Mitchell Court (Tauranga) Limited
Certificate name:	Mitchell Court (Tauranga)
Designated Auditing Agency:	Health and Disability Audit NZ
Types of audit:	Surveillance
Premises audited:	Mitchell Court
Services audited:	Rest home
Dates of audit:	Start date: 25 November 2013 End date: 25 November 2013
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	26

Audit Team

Lead Auditor	XXXXX	Hours on site	7	Hours off site	4
Other Auditors	XXXXX	Total hours on site	7	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	14	Total audit hours off site	9	Total audit hours	23
Number of residents interviewed	4	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	4	Total number of managers (headcount)	1
Number of medication records reviewed	8	Total number of staff (headcount)	27	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			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 the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Monday, 20 January 2014

Executive Summary of Audit

General Overview

Mitchell Court provides rest home level care for up to 35 residents. Occupancy on the day of the audit was 26 residents. The facility is privately owned and operated and is part of the Cavell Group. The current operational manager has been employed at Mitchell Court for over two years. A nurse manager who is a registered nurse (RN) supports her. Families and residents interviewed spoke positively of the support provided at Mitchell Court.

Six of the ten shortfalls identified in the previous audit have been addressed. These were around abuse and neglect training, integration of resident files, expired medications, remodelling of the two serviced apartments for rest home use, renovation of two bathrooms and call bells. Improvements continue to be required around timely review of assessments, care planning and review of not for resuscitation orders.

This audit identified further improvements required around first aid trained staff, weight loss management, neurological observations and aspects of medication management.

Outcome 1.1: Consumer Rights

Mitchell Court provides care and support for residents at rest home level care that focuses on the individual with residents and relatives praising the services provided with caregivers describing a philosophy of encouraging residents to remain as independent as possible. Family state that they are informed of any incidents. Complaints processes are implemented, complaints, and concerns are actively managed and documented with a complaints register. There is an improvement required around the review of 'not for resuscitation' orders.

Outcome 1.2: Organisational Management

The service is part of the Cavell Group and there is an operational manager who has been in the role for two and a half years. She is supported by the nurse manager with both having experience in aged care. The service has an implemented quality and risk management programme. This programme includes policies and procedures relevant to the service. Quality data is collected, evaluated, and used for quality improvement. The service benchmarks with another site that is also part of the Cavell Group. Staffing is as per policy and includes the operational manager and nurse manager on day shift during the week and on call. Family and residents state that there is enough staff to provide support and care. An improvement is required to ensure that each shift has a staff member with a first aid certificate.

Outcome 1.3: Continuum of Service Delivery

Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. A health needs assessment and a variety of risk assessments are completed on admission and reviewed six monthly following admissions. There is an improvement required around timely review of assessments. The consumers' needs, and goals are clearly identified in care plans and interventions clearly guide staff. There is an improvement required around addressing all identified needs in care plans. Residents and/or family have input into the development of care plans. Communication with family is well documented. Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long-term care plan identify goals, and interventions and

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	Three of four not for resuscitation plans that had been determined by the GP with family input as the resident is not capable have not been reviewed in the past year.	Ensure not for resuscitation plans are reviewed annually.	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 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	In the past four weeks, there have been eight PM shifts without a staff member with a first aid certificate. The operational manager states that she always endeavours to have one staff with a first aid certificate on duty after hours, however when casual staff cover for staff absences at short notice or staff change	Ensure that each shift has a staff member with a first aid certificate.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				shifts with each other, that there may not be a staff member on shift with a first aid certificate.		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	One of four resident files sampled has not had any assessments reviewed since January 2013 despite a decline in health.	Ensure that assessments are reviewed six monthly or when health changes.	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Two of four files sampled have identified issues including weight loss and anxiety not addressed in care plans.	Ensure all identified areas of need are addressed in care plans.	90
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 Moderate			
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	(i)One resident has been prescribed ensure by the registered nurse following a recent 9 kg weight loss. The Ensure is not included in the care plan and the progress notes and fluid balance chart do not	(i)Ensure that ensure supplement drinks are given to residents requiring this and that this is documented. (ii) Ensure staff complete regular assessment and monitoring of a resident who has had a fall resulting in a knock to the head.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>indicate that the resident is receiving the Ensure. (ii) The same resident had a fall in October 2013 resulting in a knock to the head. . The resident was observed for signs of concussion and staff contacted the manager on call. However, a full set of neurological observations were not completed The manager reports that this is because caregivers are not trained to complete full neurological observations.</p>		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	<p>(i)Controlled drug checks have not occurred weekly. (ii) PRN medications do not document an indication for use on seven of eight medication charts sampled. (iii) Five of eight medication charts sampled have regular medications prescribed that have not always been signed as administered. (iv) There are two open bottles of</p>	<p>(i)Ensure controlled drug checks occur weekly. (ii) Ensure all PRN medications document an indication for use. (iii) Ensure medications are administered as prescribed. (iv) Ensure all eye drops are dated when they are opened.</p>	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				saline eye drops that had not been dated when they were opened.		
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There is one residents who self-administers inhalers and does not have a competency assessment	Ensure all residents who self-administer medicines have a current competency assessment.	180

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 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

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

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

Attainment and Risk: FA

Evidence:

Staff had training around abuse and neglect in June 2013. Staff have also completed a questionnaire around abuse and neglect. Three of three caregivers confirm knowledge of the procedure to notify the operational manager and/or nurse manager of any abuse and to document an incident form. The service records any incidents related to abuse. There are two incidents reported as physical abuse in October 2013 however, these are both residents who have had challenging behaviour towards staff when being showered or having cares completed with the abuse directed at the staff

The previous improvement required is met.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy around open disclosure. There is an interpreter policy, which includes references to resources.

Contact with family members following an incident is recorded on the accident/incident form (documented in 12 of the 15 incident forms reviewed noting that for the two resident involved, both have family visiting one to two times a week and one family member interviewed confirms that he has been informed) and in resident files reviewed. In addition, contact with the family is recorded in the progress notes and on the family communication form.

Three caregivers interviewed, the nurse manager and the operational manager interviewed confirm that family are informed of any resident accidents or incidents where harm occurs.

There are no residents currently requiring interpreting services.

D16.4b Three of three family confirm that there is good communication with the service and all state that they are informed of any incidents.

Residents interviewed (four) confirm that they are communicated with well.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

D16.1b.ii The residents and family are informed, prior to entry, of the scope of services and any items they have to pay that are not covered by the agreement.

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

The operational manager has set up an email system with some family members (whoever wants to) to keep in touch regularly. Any complaints that come through the email system or concerns are also documented in the complaints register.

Staff have had training around communication in 2013.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: PA Low
Evidence: The previous audit identified that files included a resuscitation form that had not been reviewed annually. Four files were reviewed for this audit. Three had not for resuscitation plans that had been determined by the GP with family input, as the resident is not capable. Two of these three have not been reviewed in the past year and the previous shortfall remains. One resident has a resident determined not for resuscitation order, as she is competent to make this decision. This directive has been reviewed in the past year. This continues to be an area requiring improvement.

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: PA Low
Evidence: The previous audit identified that files included a resuscitation form that had not been reviewed annually. Four files were reviewed for this audit. Three had not for resuscitation plans that had been determined by the GP with family input, as the resident is not capable. One of these three has been reviewed in the past. One resident has a resident determined not for resuscitation order, as she is competent to make this decision. This directive has been reviewed in the past year.

Finding:
Three of four not for resuscitation plans that had been determined by the GP with family input as the resident is not capable have not been reviewed in the past year.
Corrective Action:
Ensure not for resuscitation plans are reviewed annually.
Timeframe (days): 180 (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:
<p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution.</p> <p>Two complaints tracked indicate that these have been resolved in a timely manner as per the policy.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p> <p>Three of three family members and residents interviewed (four) confirm that they know how to make a complaint and all state that there is no reason for them to make a complaint but feel that any concerns would be resolved.</p> <p>A complaint in November 2012 with the Health and Disability Commission has been closed out by the Commission in August 2013 with no further actions or follow up.</p> <p>The service has changed practice in response to the complaint and has completed care documentation reviews in February, March and August 2013 and is intending to continue with the audits as well as the internal audits completed by a member of the Cavell Group.</p>

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

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

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

Timeframe (days): (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:

Mitchell Court provides rest home level care to 26 of 35 residents.

Mitchell Court is privately owned and operates as a limited liability company with the owner visiting to discuss on-going issues/quality improvement with the facility manager. The service is a member of the Cavell Group.

The operational manager is a registered nurse and midwife (without a current practicing certificate) with significant aged care auditing and over 10 years' experience in aged care management. She has been in the position as operational manager for two and a half years and has been an external auditor prior to this.

A nurse manager (40 hours a week registered nurse), Cavell Group members and the owner support her.

There is a Cavell group strategic plan 2013 with review scheduled for 2014. The mission states, "The Cavell Group is an association of five individually owned residential aged care providers. The facility is independently owned since June 2011. The strategic plan includes nine objectives and strategies for their achievement.

The service has an individual mission statement 'our philosophy is to provide the highest quality of care with respect and dignity in a homelike atmosphere. To promote

and encourage a lifestyle that is as normal as possible in a loving environment that is secure and free from anxiety and stress. We recognise and support resident's individual beliefs, values and culture. We maintain an open door policy to ensure residents, staff and families can discuss concerns and complaints and know they will be dealt with in a professional manner'.

The operational manager reports monthly to the owner on a range of operational matters including infections, accidents and incidents, corrective action forms, hospitalised clients, short stay clients, new clients, meetings held or attended, training held or attended, health and safety, audits/quality issues, new staff, staff resigning and comments and general issues.

ARC, D17.3di (rest home): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

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

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

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:

Mitchell Court has a documented quality and risk management system that is overseen by the operational manager, the owner and the Cavell Group. Mitchell Court has a quality plan June 2011 – December 2013 that is documented. The plan has been reviewed in January and September with progress against goals documented.

There is a risk management plan with risk factors identified, consequence, likelihood, relative score, control effectiveness and control reference actions. Discussions with the nurse manager, two caregivers and review of meeting minutes demonstrate staff involvement in quality and risk activities. There are meetings held at Mitchell Court that include the following: monthly staff meetings, quality/management meetings that includes staffing, roster, education, health and safety etc; quarterly activities meetings, two monthly resident/family meetings. There is an internal audit schedule implemented with corrective actions documented when issues arise from meeting minutes and from audits. The service used to have health and safety meetings separately however these are now amalgamated into the staff meetings. Minutes documented indicate that meetings are held as per schedule.

Another member of the Cavell Group completes the internal audits with reports provided to the operational manager for on-going action if required. There is monitoring quarterly of kitchen, laundry, bedrooms and bathrooms and sluice cleaning. These are completed by staff on site along with other checks such as infection control monitoring, food and fridge/freezer temperatures. There is a night shift cleaning schedule completed. There are annual resident and relative surveys undertaken with the last collated in December 2012 and one recently circulated in 2013 – waiting to be collated.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements and the Cavell Group reviews these appropriately. The quality and risk system is documented and links with associated policies/procedures. Clinical policies and procedures are in place for the rest home.

There is a document control process implemented that includes a review date and sign off by the general managers/owners.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is addressed through the monthly staff meetings.

A hazard register is documented and hazard identification forms identify that any hazards are addressed in a timely manner and discussed at meetings.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

D19.2g There are individual assessments of falls and strategies documented in care plans.

The service benchmarks with another home that is part of the Cavell Group.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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: <p>D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the Ministry of Health. The operational manager has informed the DHB and HealthCERT of a recent medication error (Oct 2013). The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Meeting minutes from the monthly staff meetings reflect discussions of incidents/accidents and actions taken. A review of incident/accident forms for the service (15 reviewed) identifies that all incident forms are fully completed and include follow-up actions taken if required.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

A copy of the annual practicing certificate is on file for the nurse manager, doctors, podiatrist, dietician, pharmacist indicating that all relevant staff have a current APC. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.

Four staff files reviewed (one nurse manager, two caregivers, one chef) include application, referee checks, police checks for new staff employed since the operational manager was appointed training and development records.

Mitchell Court has in place an orientation/induction programme that includes a pack of information provided to new staff, a staff handbook and relevant information. There is an implemented education plan (sighted for 2013) and this is well implemented. The annual training programme well exceeds eight hours annually.

Annual formal performance reviews are in place for reflective practice and setting goals including up skilling or other training or qualification and three of four files reviewed include a current performance appraisal. The nurse manager has had a performance appraisal in 2013. This was with the owner in Auckland at the time of the audit.

D17.7d: There are implemented competencies for staff relating to medication, restraint, food safety, hand washing, infection control, BSL, fire, manual handling, eye care, care and showering, wound care, laundry. Staff complete questionnaires monthly as part of the education programme including; restraint, medication, infection control, Maori health, Code of Rights, health & safety, fire safety, bullying, chemical safety, hand hygiene, sexuality & intimacy.

The nurse manager is supported to maintain professional competency and has completed the following in 2013: dementia series through the Midlands Regional Dementia Behavioural Support and Advisory Service, wound care, palliative care lecture series, palliative care course through Hospice NZ, and attendance at Cavell Group RN education programme.

Employee training records are maintained with the following topics completed by staff in 2013: fire evacuation, dementia/challenging behaviours, joints, oral care, continence, infection control and pandemic planning (March and June), open disclosure/complaints/advocacy, hand hygiene(March), documentation and medication, restraint and enablers, lifting and handling residents. The operational manager keeps a spreadsheet of attendance at training, completion of questionnaires and competencies.

The new caregiver interviewed confirms that there was a well-implemented orientation programme that includes a buddy process prior to working independently. She confirmed that a medication competency was completed prior to giving medications.

Three of three caregivers confirm that the training programme adds value and is relevant to their role.

An improvement is required around having a staff member with a first aid certificate on each duty.

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

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

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

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 Low
<p>Evidence:</p> <p>The nurse manager is supported to maintain professional competency and has completed the following in 2013: dementia series through the Midlands Regional Dementia Behavioural Support and Advisory Service, wound care, palliative care lecture series, palliative care course through Hospice NZ, and attendance at Cavell Group RN education programme. Employee training records are maintained with the following topics completed by staff in 2013: fire evacuation, dementia/challenging behaviours, joints, oral care, continence, infection control and pandemic planning (March and June), open disclosure/complaints/advocacy, hand hygiene(March), documentation and medication, restraint and enablers, lifting and handling residents. The operational manager keeps a spreadsheet of attendance at training, completion of questionnaires and competencies.</p> <p>The new caregiver interviewed confirms that there was a well-implemented orientation programme that includes a buddy process prior to working independently. She confirmed that a medication competency was completed prior to giving medications. There are six staff members, the nurse manager and the operational manager with a first aid certificate. The operational manager documents the roster with a staff member with a first aid certificate on each shift as much as possible. The operational manager states that two other caregivers have completed first aid training as part of their HCA training at the BOP Polytechnic. However, the certificates have not been presented to the staff yet, and are not available at the service to confirm this.</p>
<p>Finding:</p> <p>In the past four weeks, there have been eight PM shifts without a staff member with a first aid certificate. The operational manager states that she always endeavours to have one staff with a first aid certificate on duty after hours, however when casual staff cover for staff absences at short notice or staff change shifts with each other, that there may not be a staff member on shift with a first aid certificate.</p>
<p>Corrective Action:</p> <p>Ensure that each shift has a staff member with a first aid certificate.</p>
Timeframe (days): 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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 governance policy states that staffing levels shall be adequate to meet the needs of client care. (NZS 8134 Section 2.7). The workload management policy states that workload monitoring is undertaken at all sites on a regular basis. There is a policy around acuity and staffing ratio.

There is a documented rationale for staffing the service. Staffing rosters were sighted with staff on duty to match the needs of different shifts.

Key roles are as follows: operational manager and nurse manager - full time Monday to Friday. The operations manager and nurse manager share week about on call and the nurse manager is a backup for clinical issues to the operational manager if needed.

There are a total of 27 staff including cleaners total of 37 hours per week, Monday to Friday, maintenance 25 hours per week, kitchen manager, cook, kitchen hand seven days per week, laundry - five hour per day for seven days a week, three activities coordinator working 20 hours a week and caregivers (three on AM; two on PM and night).

Interviews with three caregivers across night, morning and afternoon shift and the manager and nurse manager confirm that staffing levels are adequate.

Three of three families and four of four residents confirm that there is sufficient staff on duty at all times.

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.)*

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

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

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

Attainment and Risk: FA

Evidence:

The previous audit identified that resident files were not integrated. This issue has been resolved and the facility now has one folder, which contains care plans, progress notes, and another file with all other information relating to the resident.

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

All records pertaining to individual consumer service delivery are integrated.

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; D16.5cj; 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:

D16.2, 3, 4: The four resident files reviewed identified that an initial health needs assessment and care plan was completed within 24 hours and all files identify that the long-term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the nurse manager and amended when current health changes occur (see CAR 1.3.5.2). All four care plans evidenced evaluations completed at least six monthly. The activity coordinators have completed activity assessments and the activities sections in care plans. Four residents interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. There are family contact records, which were completed for all residents.

D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review was evidenced as occurring on review of resident's files with acute conditions. A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment, d) pain assessment e) mini nutritional assessment and f) depression scale (see CAR 1.3.4.2 relating to out of date assessments for the resident). Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Four files reviewed identified integration of allied health and a team approach is evident. The GP was not available to be interviewed during the audit.

Tracer Methodology:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Standard 1.3.4: 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: PA Low

Evidence:

A range of assessment tools were completed in all four resident files on admission including: a) falls risk assessment b) pressure area risk assessment, c) continence assessment, d) pain assessment e) mini nutritional assessment and f) depression scale. These are repeated six monthly in three of four files sampled. The other resident has not had any assessments reviewed since January 2013 despite a decline in health. This previously identified shortfall has not yet been fully 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: PA Low

Evidence:

A range of assessment tools were completed in all four resident files on admission including: a) falls risk assessment b) pressure area risk assessment, c) continence assessment, d) pain assessment e) mini nutritional assessment and f) depression scale. These are repeated six monthly in three of four files sampled.

Finding:

One of four resident files sampled has not had any assessments reviewed since January 2013 despite a decline in health.

Corrective Action:

Ensure that assessments are reviewed six monthly or when health changes.

Timeframe (days): 90 (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: PA Moderate

Evidence:

The sample of files reviewed included; XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

A review of four resident files identifies the use of short term and long-term care plans. These reflect variances in resident health status. They are current in two of four and there is evidence of six monthly reviews, which is signed by the nurse manager who is a registered nurse in four of four files. The previous audit identified that not all

identified issues were addressed in care plans. This shortfall has not yet been addressed with two of four files having identified issues including weight loss and anxiety not addressed in care plans. A letter from HealthCERT dated 12 August 2013 requested follow up relating to short-term care plans. All four files sampled had recent previous short-term care plans that have been evaluated and closed off for relevant issues including UTI's and chest infections. The care plan is completed within three weeks of admission by the nurse manager providing a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. This is supported by other allied health care professionals providing input such as physiotherapist, mental health services for older people and podiatrist. Care plans include clear direction for staff and are reflected in the progress notes.

File of a resident assessed as a high falls risk reviewed contained a falls risk assessment and interventions documented in the care plan to assist with the reduction of potential for falls include directions such as; ensuring that walking frame is placed within residents easy reach, that call bell is placed within reach, that appropriate well-fitting footwear is worn and that room is kept clutter free to allow for ease of mobilising.

D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations.

All four resident files reviewed identified that family were involved.

D16.3k: Short-term care plans are in use for changes in health status.

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: PA Moderate

Evidence:

The sample of files reviewed included XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

A review of four resident files identifies the use of short term and long-term care plans. These reflect variances in resident health status. They are current in two of four and there is evidence of six monthly reviews, which is signed by the nurse manager who is a registered nurse in four of four files. A letter from HealthCERT dated 12 August 2013 requested follow up relating to short-term care plans. All four files sampled had recent previous short-term care plans that have been evaluated and closed off for relevant issues including UTI's and chest infections.

Finding:

Two of four files sampled have identified issues including weight loss and anxiety not addressed in care plans.

Corrective Action:

Ensure all identified areas of need are addressed in care plans.

Timeframe (days): 90 (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 Moderate

Evidence:

Four resident files were reviewed. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, and nurse manager. A review of short-term care plans, long-term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews. The nurse manager and operational manager are responsible for the education programme and ensure staff have the opportunity to receive updated information and follow best practice guidelines. The nurse manager completes residents' care plans. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all four residents' progress notes sighted). When a resident's condition alters, the nurse manager initiates a review and if required, arranges a GP visit or a specialist referral. The three caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. Four residents and three family members interviewed were complimentary of care received at the facility.

One resident has been approved Ensure by the registered nurse following a recent 9 kg weight loss. The Ensure is not included in the care plan and not recorded in the progress notes and fluid balance chart. The same resident had a fall in October resulting in a knock to the head. The resident was observed for signs of concussion and staff contacted the manager on call. However, a full set of neurological observations were not completed. The manager reports that this is because caregivers are not trained to complete full sets of neurological observations. These are areas requiring improvement.

D18.3 and 4 Dressing supplies are available and stored in a locked cupboard in the hallway. Wound assessment and wound management plans are in place for three residents with a wound - a skin tear, a chronic ulcer and a broken blister.

The nurse manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

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

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

During the tour of facility, it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.

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:

Four resident files were reviewed. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, and nurse manager. A review of short-term care plans, long-term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews. The nurse manager and operational manager are responsible for the education programme and ensure staff have the opportunity to

receive updated information and follow best practice guidelines. The nurse manager completes residents' care plans. Care delivery is recorded and evaluated by caregivers on each shift (evidenced in all four residents' progress notes sighted). When a resident's condition alters, the nurse manager initiates a review and if required, arranges a GP visit or a specialist referral. The three caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. Four residents and three family members interviewed were complimentary of care received at the facility.

Finding:

(i) One resident has been approved Ensure by the registered nurse following a recent 9 kg weight loss. The Ensure is not included in the care plan and the progress notes and fluid balance chart do not indicate that the resident is receiving the Ensure. (ii) The same resident had a fall in October 2013 resulting in a knock to the head. The resident was observed for signs of concussion and staff contacted the manager on call. However, a full set of neurological observations were not completed. The manager reports that this is because caregivers are not trained to complete full neurological observations.

Corrective Action:

(i) Ensure that ensure supplement drinks are given to residents requiring this and that this is documented. (ii) Ensure staff complete regular assessment and monitoring of a resident who has had a fall resulting in a knock to the head.

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an activities coordinators (three who work two days, two days and one day respectively) at Mitchell Court who is responsible for the planning and delivery of the activities programme. Activities are provided in the lounge, dining area, garden (when weather permits) and one on one input in resident's rooms when required. On the day of audit, residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events.

The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the activities care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.

Mitchell Court has its own van for transportation. Residents interviewed described attending concerts, going shopping, lunches, picnics, and visits to Care and Craft.

The operational manager reports that the activities programme is undergoing a review and the current staff have been made redundant to allow for the employment of one person to oversee the entire programme (still at 20 to 25 hours per week) which will now be provided up to 4.30pm. This has been decided in consultation with mental health services for older people to better support those residents with dementia and 'sundowning'. D16.5d Resident files reviewed identified that the individual activity plan is reviewed during care plan review.

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

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

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

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: <p>There is at least a three monthly review by the medical practitioner. D16.4a Care plans are reviewed and evaluated by the registered nurse manager six monthly or when changes to care occur as sighted in four of four care plans sampled. There are short term care plans to focus on acute and short-term issues. Six short term care plans (STCP) s reviewed evidence evaluation and are signed and dated by the nurse manager when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; chest infections and urinary tract infections (UTI's). Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift. A handover sheet completed daily by the nurse manager identifies any changes to health status and care directives. ARC D16.3c: All initial nursing assessment/care plans were evaluated by the nurse manager within three weeks of admission.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in the staff office situated in one of the wings. . Individually packed controlled drugs are stored in a locked safe in the dispensary. Controlled drugs in blister packs are kept in a locked cupboard in the staff office. Two staff who have completed the medication competency must sign controlled drugs out. Weekly controlled drug stock takes have not occurred and this is an area requiring improvement. The service uses four weekly blister packed medication management system. Medication charts have photo ID's. There is a signed agreement with the pharmacy for the provision of services.

Staff sign for the administration of medications on a medication signing sheet. Five of eight medication administration-signing sheets show occasions where prescribed medications have not been signed as administered. This is an area requiring improvement. The medication folder includes a list of specimen signatures. Competency tests are completed annually and if there is a medication administration error.

There is currently one resident self-administering inhalers. This person does not have a competency assessment and this is a further area requiring improvement. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Seven of the eight medication charts sampled have PRN medications charted that do not document an indication for use. This is an area requiring improvement. Residents/relatives interviewed stated they are kept informed of any changes to medications.

Education on medication management occurred in February 2013.

There were no expired medications sighted during the audit. This is an improvement since the previous audit. Two sets of eye drops (polytears / saline solution) have not been dated when open. This previously identified shortfall continues to require improvement.

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in the staff office situated in one of the wings. Individual packed controlled drugs are stored in a locked safe in the dispensary. Controlled drugs in blister packs are kept in a locked cupboard in the staff office. Two staff who have completed the medication competency must sign controlled drugs out. The service uses four weekly blister packed medication management system. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Staff sign for the administration of medications on medication signing sheet.

Education on medication management occurred in February 2013.

There was no expired medication sighted during the audit.

Finding:

(i) Controlled drug checks have not occurred weekly. (ii) PRN medications do not document an indication for use on seven of eight medication charts sampled. (iii) Five of eight medication charts sampled have regular medications prescribed that have not always been signed as administered. (iv) There are two open bottles of saline eye drops that had not been dated when they were opened.

Corrective Action:

(i) Ensure controlled drug checks occur weekly. (ii) Ensure all PRN medications document an indication for use. (iii) Ensure medications are administered as prescribed. (iv) Ensure all eye drops are dated when they are opened.

Timeframe (days): 90 (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: PA Low

Evidence:

There is a policy around residents who self-administer medicines. The resident who self-administers inhalers keeps these in a safe place in his room.

Finding:

There is one residents who self-administers inhalers and does not have a competency assessment

Corrective Action:

Ensure all residents who self-administer medicines have a current competency assessment.

Timeframe (days): 180 (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:

Mitchell Court employs a chef, two cooks and one kitchen hand and all food is cooked on site. There is a five weekly rotating menu that was reviewed by a dietitian in February 2011.
A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Hand hygiene education occurred as part of infection control education.
The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the chef. Special diets are noted on the kitchen notice board, which can be viewed only by kitchen staff. Special diets being catered for include diabetic diets, one low sodium diet and three residents on a pureed diet. Weights are recorded monthly as directed by the nurse manager. Residents report satisfaction with food choices, meals are well presented. Lunchtime meal was observed being served and was attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident

likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.2: 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: <p>Reactive and preventative maintenance occurs. An external provider checks fire equipment. The building holds a current warrant of fitness, which expires 14 October 2014. Electrical equipment is checked annually and was last checked in April 2013. An external provider calibrated medical equipment in June 2013. 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.</p> <p>At the last audit a serviced apartment that the home were intending to alter to provide two further rest home rooms was checked and required changes identified. This was renovated prior to use to ensure all requirements were met and approved by the DHB. There is now a shared disabled size bathroom/toilet with locks and ramp access from the main building. Both rooms have been decorated and both rooms are suitable for use by residents requiring rest home level care. Both rooms have call bells. One of the rooms is currently occupied with a resident receiving rest home level care.</p>

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: The previous audit identified that the bathroom/toilet in the serviced apartment required refurbishing/remodelling prior to use as rest home rooms. This is now a shared disabled size 'wet area' bathroom suitable for rest home level residents. The previous audit also identified that two shower linings and a vanity in Rimu wing are peeling. These have been replaced since the previous audit. The previous shortfalls have been addressed.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: The previous audit identified that the lower lounge had no call bell and the two new rooms were to be connected to the call bell system on completion. Call bells have now been fitted in each of these areas and the issue has been addressed.

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

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

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:

The policy around restraint and enablers is applicable to the type and size of the service (rest home). Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, including definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. There are two enablers in use (bedrails) last assessed and reviewed in August 2013 and no restraints for residents. One resident is currently being reviewed for an enabler (bedrail – with the GP to sign off).

The service installed an external gate in March 2013 and has identified this as environmental restraint. The code is on the gate on both sides. The restraint register includes the gate as a listed restraint. A letter was sent to all relatives and residents were informed prior to the gates installation. The operational manager confirms that any new residents coming into the home are informed of the gate. For those residents whom the gate is used as an environmental restraint all restraint processes are implemented monitored and reviewed.

The intention of the gate is to ensure safety for residents who have a tendency to wander off the premises.

Three caregivers interviewed and the operational manager confirm knowledge of restraint, enablers and management of challenging behaviours with training last being given in January and August (questionnaire) and in August – challenging behaviour training.

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:

The infection control surveillance policy describes the surveillance programme. The surveillance data is discussed at the monthly staff meetings, management meetings one to two monthly and through the infection control working party group for the Cavell Group.

The data sheet that goes to the Cavell Group includes a qualitative discussion around the infections and number. The data includes the repeat infections in each monthly if they continue. There have been a high rate of infections in August and September documented as lower respiratory infections (nine in September identified as influenza). The operational manager and the nurse manager are able to discuss this in the context of the flu injections with 96.5% of residents having had the influenza vaccination in 2013.

There is a register of use of antibiotics.

A graph of number of infections versus bed occupancy is compared with one other sister site of the Cavell Group (rest home) and a graph generated. The infection control data is left with the minutes of the meetings in the staff room for staff to review. Trends and individual outcomes are noted and acted upon by the service.

Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.

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.)