Auckland Healthcare Group Limited

Current Status: 7 April 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

Palms Home and Hospital provides rest home and hospital level of care for up to 42 residents. The facility is owned by a husband/wife team (non-clinical) and is managed by a nurse manager who is a registered nurse. The facility is currently upgrading several rooms to provide more spacious resident rooms with en-suite facilities.

The facility has addressed three of the four shortfalls from the previous audit around complaints register, timeframe for initial assessments and restraint/enabler documentation. There continues to be an improvement required around care plan documentation.

This audit has identified the following improvements required; professional development for the nurse manager, aspects of medication documentation, the integration of activity plans, storage of gardening chemicals, shaded outdoor areas, dual-purpose beds, and the elimination of fall hazards.

Audit Summary as at 7 April 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 7 April 2014

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

Organisational Management as at 7 April 2014

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

Continuum of Service Delivery as at 7 April 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 7 April 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.		Some standards applicable to this service partially attained and of low risk.

Restraint Minimisation and Safe Practice as at 7 April 2014

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

Infection Prevention and Control as at 7 April 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:	Auckland Healthcare Group Limited
Certificate name:	Auckland Healthcare Group Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Palms Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 7 April 2014 **End date:** 7 April 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:	39

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	7
Other Auditors	XXXXX	**Total hours on site**	8	**Total hours off site**	6
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	16	Total audit hours off site	15	Total audit hours	31

Number of residents interviewed	6	Number of staff interviewed	5	Number of managers interviewed	4
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	30	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	

Declaration

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

I confirm that:

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

Dated Friday, 23 May 2014

Executive Summary of Audit

General Overview
Palms Home and Hospital provides rest home and hospital level of care for up to 42 residents. On the day of the audit there were 39 residents living at the facility. The facility is owned by a husband/wife team (non-clinical) and is managed by a nurse manager who is a registered nurse. The facility is currently upgrading several rooms to provide more spacious resident rooms with en-suite facilities. The facility has addressed three of the four shortfalls from the previous audit around complaints register, timeframe for initial assessments and restraint/enabler documentation. There continues to be an improvement required around care plan documentation. This audit has identified the following improvements required; professional development for the nurse manager, aspects of medication documentation, integration of activity plans, storage of gardening chemicals and turpentine, shaded outdoor areas, dual-purpose beds, and management of elimination of falls hazard (small step from the patio to the lawn).

Outcome 1.1: Consumer Rights
Policies and procedures outline requirements relating to effective communication and a clear and consistent approach to open disclosure. Residents and families are kept informed of any untoward event or changes in care provision. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place, which includes maintaining a complaints register; this is an improvement from the previous audit.

Outcome 1.2: Organisational Management
The governing body ensures services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner. Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice and meet legislative requirements. A monthly education and training programme is in place for staff. Staffing levels are appropriate to safely meet the needs of the residents. Required improvements are identified around professional development for the nurse manager.

Outcome 1.3: Continuum of Service Delivery
An initial assessment is completed on admission in resident files sampled. This is an improvement from the previous audit. The service delivery plans are completed by the registered nurse and evaluated within required timeframes. The previous shortfall remains around care plans to reflect resident's current needs. Documentation is required to evidence resident/family/whanau involvement in the care plan process. Integrated clinical and allied health records, staff handover and clinical observation forms evidenced appropriate interventions and service provision to meet the needs of the residents. Residents and family commented positively on the services provided. Cultural needs and preferences of the residents are well accommodated during service delivery.

The activity programme provides activities to meet individual and group recreational, emotional, social, cultural and religious preferences. Each resident has an activity assessment and social history completed following admission. There is a requirement to integrate activity plans with the resident files.
There is an appropriate medication management system and registered nurses complete competency assessments prior to medication administration and on an on-going basis. There is an improvement required around medication administration signing. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary.
There are food service policies and procedures and a link to a dietician. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Resident's individual and ethnic preferences are acted upon. Residents and family/whanau interviewed responded favourably to the food that is provided.

Outcome 1.4: Safe and Appropriate Environment

A current Building Warrant of Fitness is posted in a visible location (expiry date 27 August 2014).
The following improvements are required and include: storage of chemicals, adequate shading outdoors for residents, a small step from the patio to the lawn that is a falls hazard and dual-purpose beds.

Outcome 2: Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place. Any restraint/enabler use is recorded in an auditable format. Staff are required to attend restraint minimisation and safe practice education. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.
The restraint register has documented eight residents using a restraint (bedrails only) and one resident using an enabler (bedrails only). Residents are assessed and consent is obtained prior to a restraint/enabler being implemented. Alternatives are explored. All residents using a restraint or an enabler are monitored for safety. These are improvements from the previous audit.

Outcome 3: Infection Prevention and Control

The infection control policies and procedures reflect current best practice. Surveillance data including types of infections are appropriate for the size and complexity of the organisation. The infection control committee identify trends, corrective actions and quality initiatives that are reported to relevant staff meetings. Internal infection control audits including hand hygiene are completed.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	3	2	0	0
Criteria	0	38	0	5	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	31
Criteria	0	0	0	0	0	0	0	56

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The nurse manager was employed by the service on 6 January 2014 and is responsible for the overall management of the facility. She is a registered nurse who holds a diploma in business management. She was previously employed for four years as the business and care manager at a rest home/hospital. Her professional development relating to the management of the service is less than eight	Ensure the nurse manager attends a minimum of eight hours of professional development per year relating to the management of the facility.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				hours over the past year. Plans are in place for her to attend management and clinical professional development courses throughout the year.		
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	(i)Six of six resident records reviewed did not evidence resident/ family/whanau involvement in the care plan process. (ii) Three of six care plans do not reflect the current needs of the residents; a) there are no alternative strategies/activities documented in the care plan for the management of disturbing behaviours for two hospital level residents and one rest home resident. b) There is no diabetic management plan for one rest home resident on insulin and one hospital resident on oral diabetic medication, and c) There is no management plan for one hospital resident with seizures.	(i)Ensure there is documented evidence of resident/family/whanau involvement in the care planning process. (ii) Ensure long term care plans describe the required support and interventions to meet the resident's needs.	90
HDS(C)S.2008	Criterion 1.3.5.3	Service delivery plans demonstrate service integration.	PA Low	Activity plans are not integrated into the resident files.	Ensure activity plans are integrated into the resident files.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	Staff have used dittos on five of 12 non-packaged medication signing sheets. The dose of fentanyl patch is not documented when applied.	Ensure administration documentation complies with legislative requirements.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Gardening chemicals and turpentine were sighted on a shelf, outdoors, at the rear of the facility in an area that is accessible to the residents.	Ensure all chemicals, including chemicals used outdoors, are stored in a secure area.	30
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	The outdoors area includes tables and chairs but there is a lack of available shade for the residents.	Ensure there is adequate shading outdoors for the residents.	180
HDS(C)S.2008	Standard 1.4.4: Personal Space/Bed Areas	Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	PA Low			
HDS(C)S.2008	Criterion 1.4.4.1	Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area.	PA Low	There are 12 rooms that have been certified as suitable for dual purpose (rest home or hospital).	Ensure that these identified rooms are only used for residents assessed as rest home care once the	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.		However, these rooms are only suitable to provide rest home care.	temporary accommodation is not required.	

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: Policies and procedures outline requirements relating to effective communication and a clear and consistent approach to open disclosure. Residents and families are kept informed of any untoward event, evidenced in ten of ten accident/incident forms reviewed and in interviews with six of six residents (three rest home level and three hospital level) and one of one family member (hospital). Residents and relatives report they are also kept informed regarding any changes in care provision. The cultural diversity of the residents is varied with some residents unable to speak English. The service has multilingual staff that can provide interpreter services when family are not available. Pictorial signage is also available to assist with translation. Interpreter services can be accessed through the Counties Manukau District Health Board.

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: FA
Evidence: The services complaints policy and procedure meets requirements defined by the Health and Disability Commissioner's (HDC) Office. Included in the policy are the time frames for responding to a complaint. Complaints forms are available in a visible folder at reception. The complaints register documents the date the complaint was received, who reviewed the complaint, the date actions are to be taken and the date when actions are completed, whether the advocacy process was commenced and the date the complaint was closed with sign-off by the nurse manager. This is an improvement from the previous audit. Documentation relating to each one of the lodged complaints is held in the complaints folder. Four complaints were lodged in 2013 and one complaint has been lodged in 2014 (year-to-date). All five complaints were dealt with in a timely and appropriate manner. They have been signed off as resolved by the nurse manager. Interviews with six of six residents (three rest home level and three hospital level) and one family (hospital) confirm that they understand their right to lodge a complaint, and that the managers are approachable if they have a concern or a complaint.

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: PA Low
Evidence: The service has a clear mission, philosophy and values that include dignity, respect, compassion, quality, and advocacy. The service can provide care for up to 42 residents with 10 beds certified as rest home level and 13 beds certified as hospital level. Nineteen beds are identified as 'dual purpose' to hospital or rest home level care (link 1.4.2.1). During the audit there were eleven rest home level residents and 28 hospital level residents living at the facility. Two owners, a husband and wife, purchased the facility four years ago. They also own two other aged care facilities that are approximately 15 minutes from this facility.

One director is responsible for maintenance and the second director reports she is responsible for non-clinical day-to-day operations. Both directors are members of the Aged Care Association and Care Association New Zealand. They attend aged care conferences and seminars provided by these two aged care associations, which exceeds eight hours per year for each owner director.

The nurse manager was employed by the service on 6 January 2014 and is responsible for the overall management of the facility. She is a registered nurse who holds a diploma in business management. She was previously employed for four years as the business and care manager at another rest home/hospital. Her professional development relating to the management of the service is less than eight hours over the past year. Plans are in place for her to attend management and clinical professional development courses throughout the year.

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: PA Low
Evidence: Two owners, a husband and wife, purchased the facility four years ago. They also own two other aged care facilities that are located approximately 15 minutes from this facility. Both directors are members of the Aged Care Association and Care Association New Zealand. They attend aged care conferences and seminars provided by these two aged care associations, which exceeds eight hours per year for each owner. The nurse manager was employed by the service on 6 January 2014 and is responsible for the overall management of the facility. She is a registered nurse who holds a diploma in business management. She was previously employed for four years as the business and care manager at a rest home/hospital. Her professional development relating to the management of the service is less than eight hours over the past year. Plans are in place for her to attend management and clinical professional development courses throughout the year.
Finding: The nurse manager was employed by the service on 6 January 2014 and is responsible for the overall management of the facility. She is a registered nurse who holds a

diploma in business management. She was previously employed for four years as the business and care manager at a rest home/hospital. Her professional development relating to the management of the service is less than eight hours over the past year. Plans are in place for her to attend management and clinical professional development courses throughout the year.

Corrective Action:

Ensure the nurse manager attends a minimum of eight hours of professional development per year relating to the management of the facility.

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

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

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

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

Attainment and Risk: FA

Evidence:

The goals of the service link to: occupancy rates, staff education, repairs and maintenance, amalgamation of new national standards and systems, and investigating software options to allow for a more robust quality programme. The quality programme is understood by staff, which was evidenced in interviews with two caregivers, one registered nurse, a cook, and the activities coordinator. Quality activity results are provided to staff, evidenced in the staff meeting minutes (staff quality improvement meetings, RN meetings, and auxiliary meetings).

All policies are subject to annual reviews, evidenced by the policy review dates at the front of each policy manual. More frequent reviews take place as changes to policy occur. The owners are members of an aged care association (CANZ) and receives policies and policy updates regularly.
A document management process controls policies and procedures. The nurse manager oversees this review process. The amendment log holds evidence of policies that have been either added or revised. Policy updates are discussed in the monthly integrated meetings with managers from the three aged care facilities, monthly staff quality improvement meetings, three-monthly RN meetings and three-monthly ancillary meetings, (meeting minutes sighted). Policies are available to staff in hard copy.

Data is collected monthly for infection rates, falls, skin tears, medication errors, absconding, complaints, restraint use and challenging behaviour. The internal audit programme also monitors a comprehensive range of activities relating to the operations of an aged care facility. An annual planner for internal audits is in place.
Audit results are provided to staff with evidence of discussions relating to any documented corrective actions (evidenced in meeting minutes).
Current quality initiatives are focused on the renovations that are underway. All residents' rooms are being enlarged, carpet throughout the facility is being replaced with vinyl flooring and the walls are getting a fresh coat of paint (link 1.4.2).

All staff interviewed (two caregivers, one RN, one activities coordinator, and the cook) report they are kept informed of quality improvements and corrective action plans.
The service has a risk management plan that documents risks associated with the service, and risk minimisation strategies. The hazard register identifies hazards although there were three hazards identified during the audit that were not included on the hazard register (link 1.4.2). Identified hazards include controls to minimise, isolate or eliminate the hazard.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA
Evidence: The nurse manager is aware of situations in which she would need to report and notify statutory authorities. The Ministry of Health was notified regarding her recent appointment. There have been no serious accidents that have necessitated reporting to OSH and the Ministry of Health. The service is committed to providing an environment where all staff are able and encouraged to recognise and report accidents and incidents. Staff receive education at orientation and as a regular in-service topic on the accident and incident reporting process. Two of two care givers and one of one RN interviewed confirms their understanding of the accident and incident reporting process. Ten incident reports were selected for review. Where there is an adverse event, a corresponding note is the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event (link 1.1.9). Each clinical event is investigated and signed off by a registered nurse.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Current copies of practising certificates are held on file and were sighted for the six registered nurses, the GP, podiatrist, pharmacists and physiotherapist. Six staff files were randomly selected for review (one nurse manager, two caregivers, one cleaner, and two registered nurses). Signed employment agreements and job

descriptions were held in all six files reviewed. All staff undergo a comprehensive orientation programme that meets the educational requirements of the ARC contract.

Caregivers are paired with a senior caregiver until they demonstrate competency on a number of tasks including personal cares. Completed induction checklists are held in staff files. The service has a mandatory education programme with sessions held each month. The registered nurses, the physiotherapist and external presenters provide education and training sessions. They are presented on more than one occasion to improve attendance rates.

Caregivers undergo Aged Care Education (ACE) training. Both caregivers interviewed have completed their basic ACE education. The nurse manager has recently attended a Health Ed Trust assessor education day. Education for the registered nurses is provided by the Counties Manukau District Health Board. Annual performance appraisals are conducted for staff, evidenced in five of the six staff files reviewed.

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

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

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

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

Attainment and Risk: FA
Evidence: Staffing levels are planned for anticipated workloads, numbers of residents and the associated skill mix necessary to provide safe care. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy. The nurse manager works Monday – Friday from 0930 to 1830.

The AM shift is staffed with one registered nurse (RN) and five caregivers, three who work for eight hours and two who work for four hours.
The PM shift with staffed with one RN and five caregivers, two who work for eight hours, one who works for two hours (during dinner), and two who work an average of four hours each.
The night shift is staffed with one RN and one caregiver.
Weekend staffing reflects an increase in four caregiver hours.
Additional RN staffing takes place for six hours on Wednesdays for the Doctor's clinic, four hours on Tuesdays for the physiotherapy clinic and alternating Saturdays for four hours to cover the dietitian's clinic.
There are dedicated laundry and housekeeping staff. Staff are required to have a minimum of one day off per week. There are currently no vacancies and agency staff are not being used.

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

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

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence:
D16.2, 3, 4: The files reviewed (three rest home and three hospital), identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a RN at least six monthly.

The caregivers and registered nurse interviewed were able to describe a handover that takes place at the beginning of each shift to oncoming staff that maintains a continuity of service delivery.

D16.5e: Six resident files reviewed identified that the GP had seen the resident within two working days. The service has a contracted GP. The GP conducts three monthly review visits and are notified by fax with any resident concerns. It was noted in resident files reviewed that the GP has a medical review stamp that states if the resident is stable and the timeframe for next visit. The GP is unavailable for interview on the day of audit.

RN's can initiate urgent transfers to the emergency department and resource nursing specialists and allied health professional as required. There is evidence of allied health professional involvement in the provision of service such as wound care nurse, physiotherapist, dietitian, podiatrist, pharmacy and mental health services for the older person. The service has a contracted physiotherapist for three hours a week, four weekly dietitian visits and six weekly podiatry visits.

Tracer Methodology: Rest home resident

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

Tracer Methodology: Hospital level resident

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

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

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

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

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)
Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: 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: FA
Evidence: Initial assessments for two of six resident files (admitted in the last year) were sampled. Initial assessments have been completed within the required timeframe. The previous finding has been addressed.

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

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

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 1.3.5: 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: An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The registered nurse develops the long term care plan from information gathered over the first three weeks. An improvement remains since previous audit around ensuring the care plans describe the required support to reflect the current needs of the resident. The resident's social, recreational, family, spiritual, emotional, individual and cultural needs are assessed on admission. An activity plan is developed within two weeks of admission. D16.3k, Short term care plans are in use for changes in health status. D16.3f; All six of six resident records reviewed did not evidence resident/ family/whanau involvement in the care plan process.

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: An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The registered nurse develops the long term care plan from information gathered over the first three weeks.

Finding: (i)Six of six resident records reviewed did not evidence resident/ family/whanau involvement in the care plan process. (ii) Three of six care plans do not reflect the current needs of the residents; a) there are no alternative strategies/activities documented in the care plan for the management of disturbing behaviours for two hospital level residents and one rest home resident. b) There is no diabetic management plan for one rest home resident on insulin and one hospital resident on oral diabetic medication, and c) There is no management plan for one hospital resident with seizures.
Corrective Action: (i)Ensure there is documented evidence of resident/family/whanau involvement in the care planning process. (ii) Ensure long term care plans describe the required support and interventions to meet the resident's needs.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: PA Low
Evidence: The resident's social, recreational, family, spiritual, emotional, individual and cultural needs are assessed on admission. An activity plan is developed within two weeks of admission.
Finding: Activity plans are not integrated into the resident files.
Corrective Action: Ensure activity plans are integrated into the resident files.
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: FA
Evidence: The family/whanau and residents interviewed reported the resident's needs were being appropriately met. Changes in health status are reported to the RN who then initiates a clinical assessment and GP review if required. The families are kept informed of resident changes to health, accident/incidents/infections/appointments as evidenced on the communication with family/whanau and community agency form held in the residents file. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.
Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.
Continence management in-services and wound management in-service have been provided.
Wound assessment, monitoring and wound management plans are in place for one wound and two pressure areas. The wound care nurse is involved in the care of the pressure areas. Chronic wounds are linked to the long term care plan. Pressure area risk assessments have been completed.
Resident diet profiles are completed on admission. Mini nutritional assessments are completed for at risk residents. The dietitian visits four weekly and assesses and follows up on diet plans. Residents are weighed monthly.
Staff write in residents' progress notes on each shift and document any changes in care or condition of residents. Significant events are verbalised at shift handovers.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
The nurse manager has reviewed the activity programme and documentation since her appointment to Palms rest home and hospital. The review has identified some areas for improvement including the opportunity for wheelchair residents to attend outings and community functions; improved documentation and the involvement of community visitors and volunteers in the home. The proposed programme has been signed off by a qualified diversional therapist. The newly appointed activity co-ordinator (three weeks) is currently orientating to the role and has experience in dementia care therapy, group therapy and manual handling through career force training and education courses. She is employed for 25 hours per week and has been proactive in developing an individual and group programme that is flexible and meets the needs of the two consumer groups. An hour and a half in the mornings is dedicated to spend one on one time with residents who are unable to or choose not to participate in group activities. Some individual activities include aromatherapy, sensory activities, massage and pet therapy. Group

sessions include exercises, gardening, balloon volleyball, arts and crafts, games, painting and other activities as suggested by the residents. There is a main lounge, smaller indoor and outdoor areas where activities can take place. The activities co-ordinator is developing activity cards with the purpose, aim and resources required for each activity to support staff and volunteers assisting with the programme at any time. The resident's social, recreational, family, spiritual, emotional, individual and cultural needs are assessed on admission. An activity plan is developed within two weeks of admission (link 1.3.5.3). Daily attendance/activity notes are maintained. A resident monthly summary is entered into the integrated progress notes. The resident's social, recreational, family, spiritual, emotional, individual and cultural needs are assessed on admission. An activity plan is developed within two weeks of admission. Six out of six residents (three rest home and three hospital) interviewed stated participation in the programme is voluntary. All stated there has been an improvement in the activity programme over recent weeks.
D16.5d. The six monthly multidisciplinary reviews are scheduled to include the activity co-ordinator and review the activity and care plan at the same time.

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:
All initial assessments and initial care plan is developed by an RN within 48 hours of admission. The long term care plan is developed within three weeks of admission and evaluated at least six monthly or if there is a change in health status. The resident/family/whanau, RN and GP are involved in the six monthly reviews. The GP conducts a three monthly physical examination and medication review of each resident. There is documented evidence that care plan evaluations were up to date in five of six resident files sampled. One resident has not been at the service six months. All changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled. ARC: D16.3c; All initial care plans were evaluated by the RN within three weeks of admission D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated. Family/whanau is notified of changes in a resident's condition evidenced by communication sheets on six if six resident files sampled. This is confirmed by the one

hospital family member interviewed.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: The medication management policies and procedures comply with medication legislative regulations. There is one main medication room with keypad access. Registered nurses only administer medications and complete annual medication competencies and education. Annual syringe driver competencies are completed. The supplying pharmacy deliver robotic regular medications and prn blister packs. All medications are checked in by an RN and signed off on the pharmacy forms. There is a list of prn medications and expiry dates that are checked monthly. All returns are stored safely until collected by the pharmacy. The pharmacy is available after hours if necessary. Controlled drugs are stored in a controlled drug safe. There is a hospital supply of controlled drugs. Weekly controlled drug checks are conducted weekly. Medications in use are kept in a locked drug trolley. The medication fridge temperature is monitored daily. All eye drops are dated on opening. There is a current GP standing order in place. There is a self-medication assessment and monitoring in place for a residents who self-medicates. Signing sheets for regular medications are pharmacy generated. Fortisip is signed for on signing sheets. Special instructions include crushable medications. There are no signing gaps on the administration sheets however; staff have used dittos on five of 12 non-packaged medication signing sheets. The dose of fentanyl patch is not documented when applied. Two RN's sign for the administration of controlled drugs. All medication charts sampled (12) had photograph identification and allergies documented. D16.5.e.i.2; Twelve medication charts reviewed (six rest home and six hospital) identified that the GP had seen and reviewed the resident at least 3 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: Signing sheets for regular medications are pharmacy generated. Fortisip is signed for on signing sheets. Special instructions include crushable medications. There are no signing gaps on the administration sheets. Two RN's sign for the administration of controlled drugs.
Finding: Staff have used dittos on five of 12 non-packaged medication signing sheets. The dose of fentanyl patch is not documented when applied.
Corrective Action: Ensure administration documentation complies with legislative requirements.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)
Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: There is a main cook on duty from 7am to 1pm and again form 3-6pm. A kitchen hand is on duty form 9am to 1.30pm. The caregivers prepare and serve breakfast. The four weekly summer and winter menu is currently being reviewed by the dietitian. All residents have a dietary requirement form completed on admission that is reviewed six monthly as part of the care plan review. A copy is held in the kitchen and the cook is aware of residents with dietary or special requirements. Meal types provided are diabetic, soft, pureed, normal and low salt. A normal menu is provided as well as island, Indian and Chinese foods. The service has residents of diverse cultures and there is evidence through resident and family interview the service accommodates their cultural food preferences. The cook has dietary plans for residents requiring high calorie intake. There is special cutlery and plates as assessed for residents to promote independence at meal times. There are two meal sittings at midday and for the evening meal. The first meal sitting is for more independent residents and the second for those residents requiring assistance. Both sittings are observed. There is adequate meal times for those residents in the first meal serving. The meals are served at acceptable temperatures for the second meal serving and staff are observed to be seated assisting the residents. Food temperatures are monitored daily. Fridge and freezers are temperature monitored weekly (sighted). Residents' Meal Preference board allows quick reference. There are daily and weekly cleaning schedules. The pantry is tidy with all foods in sealed and labelled containers. Food sighted in the fridge is date labelled. Electrical equipment has been tested and tagged. Staff are observed to be wearing appropriate protective clothing. The kitchen is locked after hours. Chemicals are stored safely. Six out of six residents interviewed are happy with the quality and variety of food served and have alternative choices offered for dislikes. D19.2. Staff have been trained in safe food handling.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Low
Evidence: A current Building Warrant of Fitness is posted in a visible location (expiry date 27 August 2014). Required improvements that were observed during the audit include the following: gardening chemicals and turpentine were sighted on a shelf, outdoors, at the rear of the facility in an area that is accessible to the residents; there is a lack of adequate shading outdoors for residents; and there is a small step from the patio to the lawn that is a falls hazard.

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

All buildings, plant, and equipment comply with legislation.

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)
The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: PA Low
Evidence: Gardening chemicals and turpentine were sighted on a shelf, outdoors, at the rear of the facility in an area that is accessible to the residents. There is a lack of adequate shading outdoors for residents and there is also a small step from the patio to the lawn that is a falls hazard.
Finding: Gardening chemicals and turpentine were sighted on a shelf, outdoors, at the rear of the facility in an area that is accessible to the residents.
Corrective Action: Ensure all chemicals, including chemicals used outdoors, are stored in a secure area.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Attainment and Risk: PA Low
Evidence: The outdoors area includes tables and chairs but there is a lack of available shade for the residents.
Finding: The outdoors area includes tables and chairs but there is a lack of available shade for the residents.
Corrective Action: Ensure there is adequate shading outdoors for the residents.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)
Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: PA Low
Evidence: The service provides for rest home and hospital level of care. There are 19 identified dual-purpose beds. Twelve of the 19 rooms are not large enough to provide hospital level of services. Currently there are 11 hospital residents (one who chooses to stay in bed) temporarily accommodated within these rooms while renovations to their

rooms are being completed. Renovations including enlarging the bedrooms and providing en-suites. Rooms viewed are almost completed and will provide sufficient space for the provision of hospital level of care. Staff and registered nurses (RN) are aware of the potential hazards when working within confined spaces with equipment. The residents interviewed are aware they are in temporary accommodation and state their needs are currently being met.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: PA Low
Evidence: The service provides for rest home and hospital level of care. There are 19 certified dual-purpose beds. Twelve of the 19 rooms are not large enough to provide hospital level of services. Currently there are 11 hospital residents (one who chooses to stay in bed) temporarily accommodated within these rooms while renovations to their rooms are being completed. Renovations including enlarging the bedrooms and providing en-suites. Rooms viewed are almost completed and will provide sufficient space for the provision of hospital level of care. Staff and registered nurses (RN) are aware of the potential hazards when working within confined spaces with equipment. The residents interviewed are aware they are in temporary accommodation and state their needs are currently being met.
Finding: There are 12 rooms that have been certified as suitable for dual purpose (rest home or hospital). However, these rooms are only suitable to provide rest home care.
Corrective Action: Ensure that these identified rooms are only used for residents assessed as rest home care once the temporary accommodation is not required.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: Restraint minimisation and safe practice policies and procedures are in place. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and uses of restraints and enablers. Enablers are voluntary and the least restrictive option. The restraint register has documented eight residents using a restraint (bedrails only) and one resident using an enabler (bedrails only). Restraint training is included in the induction programme and in-service education programme and includes staff completing a competency questionnaire. The last education session was held on 26 September 2013. The files of the one resident using an enabler and one resident using a restraint were reviewed. Evidence of an assessment and consent for the use of bedrails was evidenced in both residents' files. Alternatives are explored prior to the implementation of restraint as part of the assessment process. All residents using bedrails as a restraint or an enabler are monitored a minimum of two-hourly for safety. Both residents' care plans include the use of bedrails as either a restraint (one resident) or an enabler (**one resident**). These are improvements from the previous audit.

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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections appropriate for the size and complexity of the organisation. The nurse manager and senior RN have taken responsibility for reviewing the infection control programme and systems. Two RNs with diplomas in infection control will become the infection control co-ordinators once the review is complete. A monthly infection control committee has commenced with nominated representatives from clinical, kitchen, laundry and administration areas. The committee uses the information obtained through surveillance to plan and determine infection control activities, resources and education needs within the facility. Surveillance includes respiratory tract, urinary, skin and soft tissue, eye infections, diarrhoeal and MRSA. A record of antibiotic use is maintained in the front of the medication folder. Statistics are collated monthly including graphs and discussed at clinical, staff and quality meetings. There are internal audits including annual hand hygiene

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.)*