

J A Crossley Holdings Limited

Current Status: 12 May 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

The J A Crossley aged care facilities incorporate Crossley Court and Orewa Beach Rest Home and are located on adjoining properties in Orewa. The service provides care for up to 44 residents who require rest home level care. There were 41 residents on the day of the audit across the two facilities. This unannounced surveillance audit was undertaken to establish compliance with specified parts of the health and disability services standards and the district health board contract.

Evidence gathered indicates the residents were being treated with respect and dignity and have their rights upheld. An expected level of care and support was being provided with no further areas requiring improvement being identified. Previous improvements from the last audit have been adequately addressed.

Audit Summary as at 12 May 2014

Standards have been assessed and summarised below:

Key

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

Consumer Rights as at 12 May 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.
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Organisational Management as at 12 May 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 12 May 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 12 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 12 May 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.
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Infection Prevention and Control as at 12 May 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.
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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:	J A Crossley Holdings Limited
Certificate name:	J A Crossley Holdings Limited
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Surveillance Audit
Premises audited:	Crossley Court Holiday and Retirement Home; Orewa Beach Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 May 2014 End date: 12 May 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:	41

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	3
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2.5

Sample Totals

Total audit hours on site	16	Total audit hours off site	9.5	Total audit hours	25.5
Number of residents interviewed	6	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	33	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 26 May 2014

Executive Summary of Audit

General Overview

The J A Crossley aged care facilities incorporate Crossley Court and Orewa Beach Rest Home and are located on adjoining properties in Orewa. The service provides care for up to 44 residents who require rest home level care. There were 41 residents on the day of the audit across the two facilities. This unannounced surveillance audit was undertaken to establish compliance with specified parts of the health and disability services standard and the district health board contract.

Evidence gathered indicates the residents were being treated with respect and dignity and have their rights upheld. An expected level of care and support was being provided with no further areas requiring improvement being identified. Previous improvements from the last audit have been adequately addressed.

Outcome 1.1: Consumer Rights

Residents are communicated with in an open manner. Sufficient information is communicated and shared. All residents sign an agreement on admission which outlines the services they will receive.

The complaints process is easily accessible and communicated to residents and families. There has been one documented complaint since the last audit to the district health board and the health and disability commissioner. The last correspondence from the district health board was in February 2014 and it is thought the matter has been resolved. Records sighted confirm that the complaint was well managed.

Outcome 1.2: Organisational Management

The Crossley Court and Orewa Beach rest home is a family run business. The purpose, values, scope, direction and goals are monitored and reviewed to ensure that services remain appropriate to resident's needs. A suitably qualified and experienced facility manager is employed to manage all day to day operations. There is a sufficient quality and risk management system that is understood and implemented by all staff. Quality related data is analysed and opportunities for improvements identified. Corrective actions are developed when service short falls are identified to make improvements to service delivery. There is a system in place to document, investigate and monitor all adverse events. Incidents are managed in a timely and open/transparent manner.

Human resources are well managed with each role having clearly defined skills, knowledge, outcomes, accountabilities, responsibilities, authorities and functions of the position. There are adequate recruitment, orientation and training processes in place to ensure the right person is performing competently in the right job at all times. Staffing levels exceed minimum contractual requirements for rest home level of care.

Outcome 1.3: Continuum of Service Delivery

The residents and one of the seven general practitioners who cover this service interviewed express a high level of satisfaction with the quality of care and services provided at this service. The service provides rest home level of care, which is clearly and accurately identified in the pre-admission information. Services are provided by suitably qualified and trained staff to meet the needs of residents. Residents have an initial nursing assessment and the nursing

care plan is developed by the registered nurse after three weeks of admission. The service meets the contractual timeframes for the development, review and evaluation of the care plan. Residents are reviewed by their GP regularly and at least three monthly, or more frequently, to respond to any changing needs of the resident. The multidisciplinary team has input when the reviews occur.

The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided and staff interviewed ensure the continuity of services. The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to have links with family and the community. The residents interviewed express high satisfaction with the group and individual activities offered at the service. There was an area of required improvement from the previous audit that had been closed out with clear evidence of the resident/family involvement on the activities plans reviewed.

A safe and timely medication system is observed at the time of the audit. The service has documented evidence that staff responsible for medication management are assessed as competent. The medication records reviewed have all been reviewed by the GPs three monthly. The controlled drug medication is managed effectively and legislative requirements are met.

The meal service is well managed and the cook is very experienced. The menu plans have been reviewed by a dietitian and the winter menus have recently been commenced. Special diets and foods can be arranged to meet the individual needs of the residents. Breakfast and the evening meal are prepared at each home kitchen and the midday is prepared and transported in the Bain-Marie to one of the facilities and served hot to residents. There was an area of improvement from the previous audit which had been effectively closed out in relation to food temperature monitoring which does occur when serving meals in each of the two facilities.

Outcome 1.4: Safe and Appropriate Environment

The building has a current warrant of fitness. There have been no alterations to the building since the last audit. The area requiring improvement from the last audit relating to shelving in the laundry has been adequately addressed.

Outcome 2: Restraint Minimisation and Safe Practice

At the time of this audit no restraints are currently being used. Enablers are being used for safety purposes and with consent of the individual resident. The staff interviewed are well informed and have received education on restraint/enablers and restraint minimisation and safe practice. Clinical staff complete education as part of the orientation process and training is on-going as per the education calendar reviewed.

Outcome 3: Infection Prevention and Control

The service has infection prevention and control policies and procedures relevant to the level of care provided. The surveillance programme is adequate for the size and nature of this aged care residential service. The registered nurse and the clinical nurse are job sharing this role effectively. Surveillance management is well documented and any information is feedback to staff after all data is analysed and comparisons made from previous months.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	0	0	0	0
Criteria	0	41	0	0	0	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	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

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:

An interpreter can be accessed if required. Incidents and adverse events are managed in an open manner and there is clear evidence of family contact in incident records and residents' progress notes. All staff are identifiable. Staff wear name badges and a uniform. The Manager has an open-door policy.

Residents interviewed state they have the opportunity to talk to management or staff and are able to request changes if needed. Adequate information regarding the service is provided. All residents sign a resident agreement which outlines subsidies and services that are provided.

The district health board requirements are met. There is a process for advising non-subsidised residents of their eligibility and the process to become a subsidised resident should they wish to do so.

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 1.1.13: 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 complaints process is easily accessible to residents and families. Policies and procedures comply with Right 10 of the Code. Residents have several mechanisms from which to voice their concerns. This includes resident meetings, surveys, accessible complaint forms and family/resident meetings.</p> <p>There has been one documented complaint since the last audit. The resident’s family complained to the district health board and the health and disability commissioner. The last correspondence from the district health board was in February 2014. Records sighted confirm that the complaint was well managed.</p> <p>A complaints register is sighted. The register includes the complaint, dates and actions taken.</p> <p>Staff training was provided by a health and disability advocate on rights, including complaints, in August 2013.</p> <p>The district health board contract requirements are met.</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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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:

The mission, vision and goals of the organisation are displayed and documented. The organisation is privately owned/operated and governed by the directors. The facility manager develops organisation goals and these are approved by the directors. Organisational performance is monitored regularly through monthly facility manager/director meetings. These report on all quality related data, staffing, occupancy, risks and key components of service delivery.

Day to day operations are the responsibility of the facility manager. The facility manager is on site five days per week. The facility manager is an experienced Registered nurse with a back ground in aged care (clinical management), preceptor for foreign registered nurses, leadership training and is a member of the care association new zealand (CANZ). The facility manager is able to show evidence of exceeding the required eight hours annually of professional development activities related to the aged care sector. This includes completion of interRAI training and attendance at the CANZ professional development seminar in June 2013 (records sighted).

The facility manager's job description is sighted and confirm accountabilities, authorities and responsibilities. The facility manager's performance is monitored by the directors and the annual performance appraisal is sighted (dated October 2013).

The district health board contract requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: Not Audited
Evidence:

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures are sufficiently documented and identify quality outcomes for key components of service delivery. Policy updates are made by those who use them, or as changes are needed. The facility manager ensures that the current version of all policies, procedures and work instructions are available to staff. Review dates and version numbers are sighted on the footer of all documents. All obsolete documents are identified as such and removed from circulation. Final approval of all policies/procedures is the responsibility of the facility manager.

A quality and risk management structure is documented and quality and risk activities are fully implemented, and monitored, in practice. There is a quality programme and the facility manager documents goals for the coming years. These are approved by the director and monitored during director/facility manager meetings. Minutes of meetings sighted confirm same. It is noted that the facility manager has implemented a number of quality initiatives over the last two years which have resulted in improvement outcomes for residents. For example regular ear checks and implementation of a physiotherapy programme has helped reduced falls.

Quality and staff meetings are conducted. These are used to communicate quality related data. Meetings occur regularly and include complaints, incidents and accidents, health and safety, training, infection control, restraint and outcomes of internal audits. Any changes to service (or new improvements) are also discussed. This is verified in staff interviews and meeting records sampled.

Satisfaction surveys are also conducted annually to confirm the organisation meets the expectations of residents/family. The 2014 results are sighted and confirm general satisfaction with services. A full collation and summary report is sighted.

There is an internal audit schedule that is fully implemented. Audits are scheduled at regular intervals to cover the scope of the quality system. Internal audits are completed by the facility manager. Examples of internal audits are sighted and confirm audits are conducted as scheduled, include corrective actions, which are then communicated to staff.

Risk management is discussed at director/facility manager meetings. This is evident in records of meetings sighted and includes discussions on concerns and current risk.

Hazards are also monitored and a current hazard register is maintained. The hazard register is sighted and was last updated in January 2014. The facility manager reports that adequate insurances and the director is an accountant.

The district health board requirements are met

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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>Individual incident and accident reports are completed for each event with immediate actions noted and any follow up actions required. The facility manager/or registered nurse signs off each incident form with recommendations for improvement if required. Minutes of meetings provide evidence of discussion of incidents/accidents and actions taken. There is evidence that deficits are remedied and improvements are made.</p> <p>Two recent incidents are sampled to ensure investigation, appropriate actions and closure. Related incident reports are sighted in resident files. The incidents are well documented and essential notifications are made. Emergency actions are implemented in the event of falls and critical observations documented. Communication with family members is evident and the general practitioner is notified in a timely manner.</p> <p>The district health board requirements are met.</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: FA
Evidence: There are written policies and procedures in relation to human resource management which comply with current good employment practice.

Six staff files are sampled and confirm that the skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountability, responsibilities and authority. Staff files sampled have evidence of the required recruitment screening and there is a system for the validation of professional qualifications for both employed staff and external health professionals. All new staff are required to receive an orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures.

The organisation demonstrates a commitment to education. All health care assistants have completed training in dementia and the registered nurses have all completed interRAI training. In addition, there is a planned programme of on-going in-service education. This includes the topics required in the district health contract and records of completion are maintained. External trainers are accessed for example pharmacists, the local gerontology nurse and staff from mental health of the older person. Individual training records are maintained and confirm attendance at the required training. Records of night staff are included in the sample and confirm that attendance at training is monitored.

Staff performance is monitored in an ongoing manner. Performance appraisals are conducted annually, and records of appraisals have been consistently maintained.

The district health board requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: 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 1.2.8: 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 organisation employs 33 staff in total. This is a combination of care assistants, domestic/maintenance staff, one physiotherapist and three registered nurses (including the facility manager). The registered nurses are rostered seven days per week. The physiotherapist is rostered one day a week.

There is a documented rationale for determining service provider levels and skill mix which is cross referenced to contract requirements. The roster is sampled and confirms that staffing levels reflect the number and mix of residents, acuity of residents, lay out of facilities, staff skills and experience. Skill mix is approved by the facility manager.

The on call roster is sighted and confirms that adequate staff are accessible at all times. This is confirmed in resident and care giver interviews.

The district health board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; 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:

The six of six care plans randomly selected for review are current and up to date and are documented taking into consideration the Waitemata district health board (WDHB) needs assessment service co-ordinator's service (NASC) assessment prior to admission and subsequently the comprehensive assessment performed by the registered nurses on admission to the service. The registered nurses and the principal nurse manager all have approved and verified annual practising certificates as well as all health professionals in the multidisciplinary team for this service. The facility manager maintains a record which is updated annually.

The initial care plan is developed on admission to guide care staff and within the timeframe of three weeks the long term care plan is developed and implemented. Additional recognised assessment tools are utilised and re-evaluations occur on a regular basis to ensure interventions are appropriate and that the goals set by the individual residents can be effectively met. The staff, inclusive of care givers, kitchen manager, and the activities co-ordinator, all have significant input into the review of each individual care plan developed and implemented and during the review process which occurs six monthly or more often if required. Two care staff interviewed and the registered nurse verified that team work is encouraged and that continuity of care occurs and this is reflected in the six of six care plans and daily progress records reviewed.

There are seven general practitioners (GPs) that cover this service and one GP is available for interview. The GP stated that most of the contracted GPs are from the same medical practice which is in close proximity to this rest home. There is always a GP on call seven days a week twenty four hours a day. The medical records are well maintained and an entry is made at every contact with the residents to ensure they are up to date at all times. There is a gerontologist nurse specialist assigned to this rest home as part of the WDHB community advisory and educational support provided. Ongoing education is planned for this year and is included on the education calendar for 2014 reviewed. Appropriate education is provided for staff at all levels. Some topics available include care planning, skin problems in the elderly, cardiac disease and respiratory disease. Staff interviews (one registered nurse and two care givers) provide verification that they are well updated and skilled to care for residents.

The district health board contract requirements are met.

Tracer methodology: rest home

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

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

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

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

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

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

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: <p>The six of six resident care summaries and care plans reviewed record interventions that are consistent with the residents` assessed needs and desired goals. Observations on the day of audit indicate residents receiving care that is consistent with the residents` needs. Short term care plans (pink) also highlight the problem identified, the intervention required, signature and date evaluated. The six of six resident interviews report that the service needs of the resident are met. The registered nurse and two caregivers interviewed report that the care plans are accurate, up to date and do reflect the individual resident`s needs.</p> <p>The district health board contract requirements are met.</p>

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

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

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

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

Attainment and Risk: FA

Evidence:

The activities co-ordinator is unavailable for interview as is on leave presently. The registered nurse and the care givers clearly understand the activities programme provided daily and assist as required. A shopping outing is planned for today and residents are looking forward to this taking place. A rest home van is available for transportation and consent has already been gained when each resident is admitted to this service. Policy is in place for the activity planning and processes involved to guide staff. Information regarding each resident's activity needs and choices is gathered on admission and regularly reviewed thereafter. Relevant information is shared with members of the multidisciplinary team. Documentation of the family history, social history and life history "My life at a glance" identifies how the activities co-ordinator gains an understanding of each resident prior to developing and implementing the individual activities plan which has identified goals, interventions, expected outcomes and is signed off by the resident/EPOA and dated. This is an area of required improvement from the previous audit which has been met.

The six of six activity plans reviewed also considered activities, skills and potential capabilities, needs, limitations and precautions (if any), interest and roles including family, friends, self, community and cultural requirements. The activity programme is planned monthly and evaluated. The programme sighted and displayed is appropriate for this aged care setting. Resident meetings are held regularly and minutes of meetings are available and sighted. Each individual resident's activity plan is evaluated six monthly and is signed off by the activities co-ordinator performing the evaluation with full name and signature and the date the evaluation occurs. A copy is retained in the individual resident's file. A recreational activities sheet is used to record attendance of activities provided.

The previous area of improvement regarding residents' involvement in activity planning has been sufficiently addressed.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

Nursing reviews and assessments, medical and any specialist consultations and admission/transfer summaries are clearly documented in the six of six residents' records reviewed. Documentation reflects the evaluations of the individualised care plans are conducted six monthly and more often when required. Interventions are changed to ensure all needs and goals set can be effectively met.

If a resident is not responding to the service interventions being delivered, or a residents health status changes, then this is discussed with the relevant general practitioner (GP) or the GP on call for the service and the GP interviewed validated this information. Short term care plans are sighted for wound care, infections, and any significant changes in mobility, changes in food and fluid intake and skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes.

The multidisciplinary reviews are completed and information is available and reviews are sighted in the residents' records. Six of six resident reviews confirm their input as able into the reviews. No family are available for interview for this onsite audit. The registered nurse interview verifies that family/whanau are able to consult with them anytime and if they have any concerns an appointment with the GP concerned can be arranged or the family can attend in person when the doctor is visiting the facility on arranged days. If progress is different than expected the family is always notified and this information is provided or communicated to the family as soon as possible. This is then clearly documented in the progress records of the individual resident. The facility manager report is completed for each shift by the senior staff member on shift to document and highlight any issues, incidents or information about residents that are unwell or if the GP is contacted.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <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: FA
Evidence: <p>This service has appropriate policies and procedures in place to reflect safe and timely medicine management. Procedures comply with current legislative requirements. One of the seven contracted general practitioners interviewed ensures that reconciliation of all medications occurs with the contracted pharmacist on a regular basis. All medication records are reviewed by the GPs three monthly and the medication records reviewed 12 of 12 evidence this has occurred. The facility manager, two registered nurses, three clinical assistants and care givers are all trained in medication management and have completed medication competencies. The lunchtime medication round was observed in both rest home facilities which are next door to one another. The medication rounds are managed in a safe and appropriate manner. Currently no residents are self-medicating medications. There is a policy in place for residents self-medicating under supervision if required to guide staff.</p> <p>Medications are delivered by the pharmacist as ordered daily or weekly. The monthly blister packed medication packs when delivered are checked by the registered nurses. If there are any errors or concerns the pharmacist is notified. The blister-pack system works very well as reported by the registered nurse and two senior care givers interviewed. The medications are stored safely in a locked cupboard and in the trolleys (2) provided and utilised for the medications rounds are locked and stored appropriately when not in use. The controlled drugs are stored in a locked container in a locked cupboard and the controlled drug book is dated and the contents pages are clearly documented. The two registered nurses are responsible for checking the controlled</p>

drugs weekly. Entries and balances are correct and checks and balances are documented in red pen when reviewed. The RNs attend relevant study days and maintain attending additional education externally and help to provide the necessary in-service education for the staff as sighted on the education calendar for 2014.

The district health board contract requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence: The food service preparation is undertaken within appropriate areas using appropriate staff and equipment. The rubbish is collected weekly by the Auckland City Council rubbish collections and recycling services. The main kitchen for this service is located at Orewa Beach Rest Home with the main

meal of the day being prepared then transported in a bain-marie to the other facility, Crossley Court. Breakfast and the evening meal are prepared in each home separately. The food is monitored by the cook prior to transportation, on receipt and before serving. Temperatures recorded evidence food temperatures are well maintained. The cook is very experienced and has completed food safety training every three years. The cook was previously a home economics teacher and has been employed in this role for fourteen years. The cook works 7am until 1pm daily (36 hours) per week and there is another cook that covers Tuesdays and for any leave required.

The menu is planned in four week cycles and the winter menu commenced on the 1 May 2014. The menus have been reviewed and approved by a dietitian. The menu plans are appropriate for older people and recognised ministry of health and eldercare guidelines have been used when developing the menus. A staff member does all the baking including birthday cakes and homemade biscuits. Special days are celebrated (e.g. birthdays, anniversaries, Easter, Christmas and others). Each second month on a Wednesday an ethnic food special menu is planned and the dining room is decorated and the staff member organising the day dresses in national ethnic costume. This was discussed at interviews and this event is enjoyed by staff, residents and families. Every Thursday happy hour is encouraged with beverages, music and finger foods. Special diets such as gluten free and diabetic diets are managed effectively. Appropriate utensils and lip plates are available for residents needing these types of resources to meet their needs. The menu board is visible for all residents and the daily menu is displayed.

The cook is responsible for the ordering of all food, checking supplies on arrival when delivered and the rotation of foods that are stored. Additional foods can be purchased from the local supermarket such as bread twice weekly and every Friday fruit and vegetables are delivered. Food temperatures and fridge/freezer temperatures are closely monitored every third day. This is an area of required improvement from the previous audit that has been met. The care staff interviewed are fully informed about hand hygiene. Ongoing education for all staff as per the education calendar is available and foodservice and etiquette and food presentation is scheduled for June 2014.

The district health board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: A building warrant of fitness is displayed that expires on 16 May 2014.

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>

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA
Evidence: The area of improvement regarding deteriorating shelving in the laundry has been adequately addressed. The laundry is sighted. The said shelves have been painted and comply with infection control guidelines.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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:

There are policies and procedures in place to ensure any restraint use is actively minimised. Policy defines enablers are voluntarily used by a resident following appropriate assessment. When an enabler is used consent will be sought and considered. There are currently in use 10 bed-guards used as enablers not restraint. The restraint/enabler register is up to date and verifies the name of the resident, date of birth, date enabler commenced, type of enabler used and the evaluations which occur. Interviews with the registered nurse and two of two caregivers demonstrate knowledge and understanding of the definition of an enabler and the process to be followed should a restraint be used. Staff education is provided annually. Restraint education inclusive of managing challenging behaviour de-escalation was provided September 2013.

The district health board contract requirements are met.

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 aim of the infection prevention and control policy and procedures is to ensure the provision of service which is consistently safe and infection free. The infection control co-ordinator role is shared by two registered nurses one of whom is the designated clinical manager. One registered nurse is available and at interview is very informed and has received education specifically for this role. The infection control surveillance programme is well managed for the size and nature of this residential aged care service. The surveillance methodology is described and implemented effectively. Surveillance reporting is valuable for obtaining incidence of infection types which are monitored on a monthly basis.

Expert advice can be sought from the contracted general practitioner interviewed and or the microbiologist from the laboratory service for this region. Infection control education is provided to all staff regularly and this is identified on the education calendar for 2014 reviewed. Infections such as urinary tract infections, respiratory infections (upper respiratory of lower respiratory and colds/influenza), eye and wound infections are reflected in the surveillance monitoring programme. Any trends identified or issues are reported to the facility manager. Feedback is given to staff and staff meetings are held three monthly which include infection control and surveillance. Minutes of meetings are available and sighted. The surveillance programme is clearly linked to the health and safety and risk management systems for this service.

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