

Benhaven Care Limited

Current Status: 15 May 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification 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

Benhaven rest home provides rest home and residential disability level care for up to 19 residents. On the day of the audit there were 17 residents. The registered nurse/manager has been in the role since February and is supported by the owners.

This audit identified that the following improvements are required around: informed consent, cover for temporary absence of the registered nurse/manager, incident reporting, care planning, delivery and evaluation, activity plans, medication management, fridge temperature monitoring, frequency of fire drills and education for the infection control coordinator.

Audit Summary as at 15 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 15 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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 15 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 15 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 15 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.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 15 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 15 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.		Some standards applicable to this service partially attained and of low risk.
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Audit Results as at 15 May 2014

Consumer Rights

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights. Policies are being implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives/whanau/advocates. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Care plans accommodate the choices of residents and/or their family/ Enduring Power of Attorney (EPOA). Complaints and concerns are managed. There is a required improvement around informed consent.

Organisational Management

The registered nurse/manager was appointed at the beginning of the year. There is no formalised cover for Behaven in the event of a temporary absence of the registered nurse/manager and this is an area of improvement. Benhaven rest home has a quality and risk management system in place that is being implemented. Key components of the quality management system link to the monthly staff meetings. The service is monitoring data and implementing corrective actions. Resident/family satisfaction surveys are completed annually and resident meetings are held. Health and safety policies and processes are implemented to manage risk. While discussions with families identified they are informed of changes in resident health status, this is not documented and is an area of improvement. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually covering relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Consumer information is relevant and appropriate.

Continuum of Service Delivery

There is a needs assessment completed prior to entry to Benhaven. The information pack includes all relevant aspects of service and this is provided to residents and/or family/whanau/EPOA. Care plans are individualised and goal oriented. Short term care plans are utilised for changes in health status such as infections. Referral to other health and disability services occurs when appropriate. Residents' clinical notes are integrated to ensure service delivery reflects continuity of care including input from all providers involved. A new activities co-ordinator has recently started and works 11.5 hours per week. There is an activities programme which offers activities that are varied, age appropriate and include attendance at local community and entertainment events. There are policies and procedures for medication management. Staff responsible for medication administration are trained and have been assessed as competent. There are improvements required around aspects of care planning, delivery and evaluation; activity plans, medication management and fridge temperature monitoring.

Safe and Appropriate Environment

There is a current building warrant of fitness. There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents

involving infectious material or hazardous substances. There is a requirement for all chemical bottles to have a manufacturers label.

The residents have access to communal areas for entertainment, recreation and dining. The service provides adequate space allowing residents to move safely around in their rooms and the facility. Residents are provided with hygienic cleaning and laundry services, which are appropriate to the setting. Residents are provided with adequate natural light, safe ventilation, and a safe environment with comfortable temperature throughout the communal areas and bedrooms. There are outside paved areas with wheelchair access, hand rails, suitable furniture and shading. There is a designated outdoor smoking area for residents. There is an improvement required around frequency of fire drills.

Restraint Minimisation and Safe Practice

Documented systems are in place to ensure the use of restraint is actively minimized. The registered nurse/manager is the restraint coordinator. There are currently three residents using enablers, two bedrails and one lap belt. Staff interviews and staff records evidence guidance has been given on restraint minimisation and enabler usage. Policies and procedures include definition of restraint and enablers. Staff education on challenging behaviour management and restraint minimisation has been provided. Documented systems are in place to ensure the use of restraint is actively minimized. Staff education on restraint minimisation has been scheduled for July 2014.

Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme meets the needs of the facility and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current practice. These reflect the needs of the service and are readily available for staff access. Documentation evidences infection control education is provided to staff as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The registered nurse/manager is the infection control coordinator and has not had infection control training, and this is an area of improvement.

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:	Benhaven Care Limited		
Certificate name:	Benhaven Care Limited		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Certification Audit		
Premises audited:	Benhaven Rest Home		
Services audited:	Residential disability services - Intellectual; Rest home care (excluding dementia care); Residential disability services - Physical		
Dates of audit:	Start date: 15 May 2014	End date: 15 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:			17

Audit Team

Lead Auditor	XXXXX	Hours on site	9	Hours off site	7
Other Auditors	XXXXX	Total hours on site	9	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors	XXXXX	Total hours on site	9	Total hours off site	4
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	27	Total audit hours off site	19	Total audit hours	46
Number of residents interviewed	8	Number of staff interviewed	7	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	14	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXX, 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	Not Applicable
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 Monday, 9 June 2014

Executive Summary of Audit

General Overview

Behaven rest home provides rest home and residential disability level care for up to 19 residents. On the day of the audit there were 17 residents. The registered nurse/manager has been in the role since February and is supported by the owners.

This audit identified that the following improvements required around: informed consent, cover for temporary absence of the registered nurse/manager, incident reporting, care planning, delivery and evaluation, activity plans, medication management, fridge temperature monitoring, frequency of fire drills and education for the infection control coordinator.

Outcome 1.1: Consumer Rights

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights. Policies are being implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives/whanau/advocates. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Care plans accommodate the choices of residents and/or their family/ EPOA. Complaints and concerns are managed. There is a required improvement around informed consent.

Outcome 1.2: Organisational Management

The registered nurse/manager was appointed at the beginning of the year. There is no formalised cover for Behaven in the event of a temporary absence of the registered nurse/manager and this is an area of improvement. Behaven rest home has a quality and risk management system in place that is being implemented. Key components of the quality management system link to the monthly staff meetings. The service is monitoring data and implementing corrective actions. Resident/family satisfaction surveys are completed annually and resident meetings are held. Health and safety policies and processes are implemented to manage risk. While discussions with families identified they are informed of changes in resident health status, this is not documented and is an area of improvement. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually covering relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Consumer information is relevant and appropriate.

Outcome 1.3: Continuum of Service Delivery

There is a needs assessment completed prior to entry to Behaven. The information pack includes all relevant aspects of service and this is provided to residents and/or family/whanau/EPOA. Care plans are individualised and goal oriented. Short term care plans are utilised for changes in health status such as infections. Referral to other health and disability services occurs when appropriate. Residents' clinical notes are integrated to ensure service delivery reflects continuity of care including input from all providers involved. A new activities co-ordinator has recently started and works 11.5 hours per week. There is an activities programme which offers activities that are varied, age appropriate and include attendance at local community and entertainment events. There are policies and procedures for medication management. Staff responsible for medication administration are trained and have been assessed as competent. There are improvements required around aspects of care planning, delivery and evaluation; activity plans, medication management and fridge

temperature monitoring.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness. There are documented processes for waste management. The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. There is a requirement for all chemical bottles to have a manufacturers label. The residents have access to communal areas for entertainment, recreation and dining. The service provides adequate space allowing residents to move safely around in their rooms and the facility. Residents are provided with hygienic cleaning and laundry services, which are appropriate to the setting. Residents are provided with adequate natural light, safe ventilation, and a safe environment with comfortable temperature throughout the communal areas and bedrooms. There are outside paved areas with wheelchair access, hand rails, suitable furniture and shading. There is a designated outdoor smoking area for residents. There is an improvement required around frequency of fire drills.

Outcome 2: Restraint Minimisation and Safe Practice

Documented systems are in place to ensure the use of restraint is actively minimized. The registered nurse/manager is the restraint coordinator. There are currently three residents using enablers, two bedrails and one lap belt. Staff interviews and staff records evidence guidance has been given on restraint minimisation and enabler usage. Policies and procedures include definition of restraint and enablers. Staff education on challenging behaviour management and restraint minimisation has been provided. Documented systems are in place to ensure the use of restraint is actively minimized. Staff education on restraint minimisation has been scheduled for July 2014.

Outcome 3: Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme meets the needs of the facility and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current practice. These reflect the needs of the service and are readily available for staff access. Documentation evidences infection control education is provided to staff as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The registered nurse/manager is the infection control coordinator and has not had infection control training, and this is an area of improvement.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	34	0	5	5	1	0
Criteria	0	82	0	5	5	1	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	5	0	0
Criteria	0	0	0	0	0	8	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	a) Four out of six files reviewed did not have all consents signed; b) Two admission agreements could not be found.	a) Ensure all consents are signed; b) Ensure all residents have a signed admission agreement.	60
HDS(C)S.2008	Standard 1.2.2: Service Management	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.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.2.1	During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	PA Moderate	At the time of audit the registered nurse/manager was employed fulltime and	A suitably qualified and experienced person is available to cover temporary absence of the RN/manager.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				was on-call 24/7. While the owner/s live on site, and are available afterhours, they are non-clinical and new to the health industry.		
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	There is an open disclosure policy that describes the process of family notification following resident incidents. Interview with staff suggests clarification around process is required. One incident (March 2014) that resulted in skin tears following a fall was traced back to the resident file, while the incident was recorded there was no record that family were informed.	Clarify responsibility in respect of family notification following resident incidents, and ensure notification is documented.	60
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	a) Six of six files did not contain a documented nutritional assessment on admission. b) Five out of six charts did not evidence a six monthly	a) Ensure appropriate assessments are completed on admission and at the six monthly reviews; b) Ensure nutritional assessments are completed for those with	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				nutritional assessment. c) A nutritional assessment was not completed for a resident with unintentional weight loss. d) There was no evidence of a pain assessment for one resident who is experiencing pain in her knees and has prn medication charted.	unintentional weight loss, c) Ensure pain assessments are completed.	
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
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 Low	a) One care plan was not reviewed within given timeframes. b) One out of six files did not evidence an activity plan	a) Ensure care plans are reviewed within given timeframes. b) Ensure all residents have an activity plan.	60
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	In five of six files the interventions did not reflect the residents assessed needs.	Interventions are recorded that reflect the residents assessed needs.	60
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or	PA Moderate	Five out of six care plans and five out of six activity plans were not evaluated within given timeframes.	Ensure all care plans and activity plans are evaluated within given timeframes.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		intervention, and progress towards meeting the desired outcome.				
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	a) There are no documented three monthly reviews evidenced on 12 out of 12 medication charts. b) Eight out of 12 medication charts reviewed did not give indications for the use of prn medication. c) Three out of 12 administration charts evidenced transcribing. d) The caregiver giving out lunch time medication was observed not checking drugs against the medication chart. e) One resident has been given medication for 11 days when the medication chart does not have it prescribed.	a) Ensure three monthly reviews are documented on the medication chart. b) Ensure prn medications give indications for use. c) Ensure that transcribing ceases. d) Ensure that medication is checked against the medication chart before administration. e) Ensure that only prescribed medications are administered.	7
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current	PA Low	One of the fridges has been consistently recording a temperature of between 48 and 50 degrees Fahrenheit.	Take corrective action to ensure fridge temperatures are maintained at acceptable levels.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		legislation, and guidelines.				
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	A fire drill has not been carried out in the last six months (last completed 04/07/2013).	Complete a fire drill.	60
HDS(IPC)S.2008	Standard 3.4: Education	The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	PA Low			
HDS(IPC)S.2008	Criterion 3.4.1	Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.	PA Low	The registered nurse/manager who is the infection control coordinator for the facility has not had recent infection control training	Attend infection control training appropriate to the size and complexity of the facility.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

Benhaven rest home has information available on the Code of Health and Disability Services Consumers' Rights. There is a code of rights policy in place that describes the code and the responsibilities of staff. Caregivers (three) interviewed are familiar with the policy. They could describe ways in which residents rights are acknowledged and incorporated in their day to day work such as obtaining informed consent, resident choice and complaints procedure. Code of rights training is scheduled for August this year. Code of Rights posters were observed displayed in the hallway and dining room of the rest home.
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Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

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>
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Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

The service has information available on the Code of Health and Disability Services Consumers' Rights (the Code). The Code is displayed in the foyer of the service and posters are on the wall in hallways and dining room. Information in relation to the service is in a format that suits the needs of residents. Residents interviewed had an understanding about their rights in respect of the Code.

D6,2 and D16.1b.iii The information pack provided to rest home residents on entry includes how to make a complaint, the Code pamphlet and information on Advocacy and H&D Commission.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention 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.)

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

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

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

Attainment and Risk: FA

Evidence:

The service has policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code. Three caregivers interviewed could describe examples of giving residents choice including: what time they would prefer a shower or breakfast, choices on food, what time they would like to get up, what clothes they would like to wear and what activities they would like to attend/participate in. This was confirmed on discussion with residents. D14.4 Privacy and Dignity (May 2012) and work instructions: Resident Welfare - Care of Resident Property provide guidelines for staff. Three caregivers and four relatives confirm personal belongings are not used as communal property or lent to others. In addition they were all able to discuss ways in which resident privacy is maintained. The staff were respectful on entering a resident's room and gained permission before doing so. There are two double rooms, one of which is shared. In the one shared room, the residents had agreed to share the room and curtains were in place around each bed space that can be drawn to allow for privacy.

D4.1a Four rest home resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Information about the client's spiritual needs and values is collected on admission and documented. The admission form includes the religious affiliation of the resident. There is a values and beliefs section in the assessment and care plan. Resident choice is part of the client code of rights policy and this promotes the right of clients to independence. Discussions with residents and family members confirmed residents are able to choose to participate in activities and can access community resources.

Caregivers interviewed (three) could describe The Detection and Removal of Abuse and Neglect Policy (October 2012), includes behaviours of abuse and neglect, and associated indicators. Policy links to a Work Instructions Resident Welfare: Reporting Abuse, and Care of Resident Property describing actions for staff. Discussions with three caregivers identified there were no incidents of abuse or neglect. There have been no identified complaints around abuse or neglect and eight residents interviewed were very positive about the quality of care and support provided. Education on abuse and neglect is scheduled for August (2014).

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

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 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes 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 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

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

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA
Evidence: <p>A3.2 The Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). The service has policies to support practice i.e. Maori health plan and Culturally Appropriate Services. Both policies evidence review October 2012. Maori health plan and Culturally Appropriate Services policies includes health definitions, concepts and ideology, Maori models of health - te whare tapa wha, cultural safety, treaty of Waitangi, protocol for mourning and care of Maori before and after death. Education on cultural safety occurred March 2013 with seven staff attending.</p> <p>D20.1i: The plan includes contact details for local Maori, Maori health services and local Marae. Discussions with three caregivers confirms an awareness of the need to respond appropriately to individual cultural difference. One (Maori) relative interviewed informs the service manages cultural needs well and described the blessing of a room prior to occupancy.</p>

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported 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.)

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

D3.1g The service provides a culturally appropriate service by assessing resident needs on admission, a social profile is gathered as is psycho-social needs, spiritual requirements and family/significant other links. Cultural awareness training conducted in March 2013.

D4.1c Four rest home care plans reviewed included the residents' social, spiritual, cultural and recreational needs. The Culturally Appropriate Services and Individual Values and Beliefs policies support and guide staff to provide. There is a values and beliefs section in the care plan. The two young disabled resident care plans reviewed also included residents social, spiritual and recreational needs.

Eight residents interviewed inform individual values and beliefs are met, also confirmed by relatives. Church services occur weekly and caregivers (three) described one resident having attended weekly church services in the community prior to health changes.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

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 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

There are policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment or sexual harassment. These policies are supported by the code of residents' rights policy, complaints policy, abuse and neglect policy - all of which are implemented. The policies include support for the resident throughout their engagement with the service. Eight residents interviewed described feeling "respected and able to make choices." Staff training provided around Code of Rights in April 2012.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being 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.)*

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

A2.2 Services are provided at Benhaven rest home that adhere to the health & disability services standards (link findings 1.3). There is a quality improvement programme that includes performance monitoring. The service has policies and procedures with systems to provide a degree of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Policies and procedures cross-reference other policies and appropriate standards. An internal audit schedule is managed within the quality system. Staff meetings occurred March and April (2014) and discuss components of quality including

incident reporting, audit outcomes, compliments, education, restraint and infection control.

Interview with the GP informed no issues with the care at the facility. Assessments and care plans are documented in resident files reviewed (six) (link 1.3). Caregivers (three) inform an understanding of principles of aged care and state that they have on-going inservice education. The policies/procedures and systems from the previous owner continue to be in place.

Residents (eight) interviewed spoke positively about the care and support provided.

D1.3 all approved service standards are adhered to.

D17.7c. There are implemented competencies for caregivers. There are clear ethical and professional standards and boundaries within job descriptions.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

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 1.1.9: 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: D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Benhaven rest home information booklet is provided to residents on entry and this includes information around rights, complaints, abuse and neglect. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b Two rest home relatives interviewed state they are informed when their family member's health status changes (link 1.2.4.2). The two relatives interviewed who have a young disabled person in Benhaven also confirm they are notified following changes in health status. D11.3 The information pack is available in large print and advised that this can be read to residents.

The service has policies and procedures available for access to interpreter services noting that there are no residents requiring interpreting services. There is an open disclosure policy, a complaints policy and an incident and accident policy and staff have had training around the code of rights including advocacy and open disclosure in May 2013. Residents who do not have family have the name and contact details of their advocate documented in their file. Eight residents and four family members interviewed state they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur and family are invited to this.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Interviews with caregivers (three) and the registered nurse/manager confirm they are familiar with the requirements to obtain informed consent. They described asking residents what clothing they wished to wear, choice of food on menu, and if they were ready for personal care requirements. The caregivers interviewed were aware of the residents' right to decline or refuse. Resuscitation and advance directive forms are signed appropriately. Resuscitation orders are completed for residents who are competent to make the decision. Four out of six files reviewed did not have all consents signed: three out of six for outings; four out of six for labels on doors and two out of six for photographs for identification purposes. This is an area requiring improvement. Four out of six admission agreements sighted and all four had been signed. Two could not be found. This requires improvement.

D3.1.d Discussion with two relatives of rest home residents identified that the service actively involves them in decisions that affect their relative's lives. In addition discussion with two relatives of a young disabled person also inform the service involves them in care decisions.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: PA Low

Evidence:

Interviews with caregivers (three) and the registered nurse/manager confirmed that they were familiar with the requirements to obtain informed consent.

Finding: a) Four out of six files reviewed did not have all consents signed; b) Two admission agreements could not be found.
Corrective Action: a) Ensure all consents are signed; b) Ensure all residents have a signed admission agreement.
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: 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 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA
Evidence: Leaflets are available at the entrance of the service which identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff interviewed (three caregivers) are aware of the right for advocacy and how to access and provide advocate information to residents if needed. D4.1d; Discussion with eight residents and four family members identified that the service provides opportunities for the residents, family/EPOA/advocate to be involved in decisions and they are aware of their access to advocacy services. D4.1e: Four of four rest home resident files reviewed includes information on resident's family/whanau and chosen social networks. Two young disabled files includes information on social networks.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

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 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA
Evidence: <p>Discussion with the registered nurse/manager and three caregivers, eight residents and four family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.</p> <p>D3.1.e Interview with the activity officer described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens e.g. voting / census. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, trips to the cinema, social events in the community and education centres. Entertainers are included in the activities programme. The activities officer described how outings in the facility owned van are tailored to meet the interests of the residents and are flexible.</p>

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when 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 1.1.13: 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: D13.3h. A complaints procedure is provided to residents and their family in the information pack at entry. There is a complaints policy and complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family. Eight residents and four family members interviewed confirm they are aware of the complaints process and they would make a complaint to the manager of other staff if necessary. There is a complaints register and complaints folder. There were two complaints received in 2013 and none recorded for the 2014 year to date.

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 owners, who live on site have owned Benhaven since July 2013. One has a Master's degree in Business Administration and the other owner has a law degree. The owner reports the contract with the previous owners continue and essentially focusses on 'business' support. At the time of the audit the previous owners were out of the country. Since the previous audits (provisional May 2013 and surveillance November 2013) Benhaven's organisational structure has changed. While the two (non-clinical) owners remain the same, the full time manager (an enrolled nurse) and a registered nurse (worked 17 hours over three days per week) have both left the service and have been replaced by a registered nurse/manager who works fulltime (link 1.2.2). The registered nurse/manager commenced at the beginning of this year and is a new role for her. There is evidence on file of clinical in-service during 2013 (eg. stroke study day, BLS training). ARC, D17.3di (rest home): professional development activities related to managing a rest home could be strengthened. The caregiver workforce has remained stable. Benhaven has quality objectives that are monitored through trending of incident reporting. There is a process for managing shortfalls through Corrective Action Request forms that include evaluation for effectiveness and close out. Benhaven is certified to provide rest home, and residential disability (intellectual and physical) services for up to 19 residents. On the day of audit there were 17 residents, 10 rest home and seven young disabled residents.

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

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: PA Moderate
Evidence: <p>The registered nurse/manager works fulltime and at the time of audit is on call 24/7 with the backup of the owner (non-clinical) who lives on site and is new to the health industry. The owner informs she knows a registered nurse who is able to cover temporary absences, however at the time of audit there was no formal agreement in place, and the registered nurse credentials had not been sighted. This is an area of improvement.</p> <p>The service continues to use the developed policies and procedures that were in use under the previous ownership. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p>

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: PA Moderate
Evidence: <p>The registered nurse/manager is employed fulltime and is reportedly on call 24/7. The owner, who lives on site, is also available however she is non-clinical and new to the health industry. At the time of the audit the owner informed she has an informal relationship with a registered nurse who is able to cover temporary absence of the registered nurse/manager, however this relationship had yet to be formalised and the credentials of the registered nurse reviewed.</p>
Finding: <p>At the time of audit the registered nurse/manager was employed fulltime and was on-call 24/7. While the owner/s live on site, and are available afterhours, they are non-clinical and new to the health industry.</p>
Corrective Action: <p>A suitably qualified and experienced person is available to cover temporary absence of the RN/manager.</p>

Timeframe (days): 30 (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 service has a business risk assessment and management plan and this includes a quality plan. The service has in place a range of policies and procedures to support service delivery. Quality data is collected and evaluated and used for quality improvement. Key components of the quality system link to service delivery. Corrective actions are documented against identified issues as these occur through internal audits and review of incident and accidents. There is a document control system. Documents no longer relevant to the service are removed and archived.

Discussion with three caregivers and the cook identified an understanding of the policies and procedures. There are implemented health and safety policies that include hazard identification. Staff meeting minutes were sighted for May and April 2014 which included discussion about recent incidents. There is a maintenance schedule implemented and issues are managed promptly as these arise. The maintenance person works two hours per day Monday to Friday. A review of the documentation indicates that maintenance issues and hazards are resolved promptly.

Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are infection control policies and procedure, a restraint policy and health and safety policies and procedures. D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents and the identification of interventions on a case by case basis to minimise future falls.

Improvement Note:

All policies include the date the policy was last reviewed and a review date noting that policies have been reviewed last in December 2012 to March 2013. The organisational chart could be updated to reflect the recent changes – i.e. The appointment of a registered nurse/manager.

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): <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): (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: PA Moderate
Evidence: There is an open disclosure policy and family members interviewed stated they are informed of changes in health status. The policy Open Disclosure notes: Details about the incident and any harm, the disclosure, and any subsequent action will be fully documented in the residents' records. Seven incident/accident forms were reviewed across April and March (2014) and one was tracked back to the notes (rest home resident fell and incurred skin tears). There is no record of the family having been notified. In addition there was a serious event involving unwanted sexual behaviour that occurred in February (2014), and while the policy notes: Disclosure will be made in a timely manner, ideally within 24 hours of the event occurring or of the harm or error being recognised; this timeframe was not met. Interview with the caregivers and RN/manager demonstrated a different understanding of who informs family following an incident. This is an area for improvement. The provider reports the relevant authorities are informed following significant events. Training for staff around open disclosure was last held in February 2013.

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: PA Moderate
Evidence: There is an open disclosure policy and family members interviewed stated they are informed of changes in health status. The policy Open Disclosure notes: Details about the incident and any harm, the disclosure, and any subsequent action will be fully documented in the residents' records. Seven incident/accident forms were reviewed

across April and March (2014) and one was tracked back to the notes (rest home resident fell and incurred skin tears). There is no record of the family having been notified. In addition there was a serious event involving unwanted sexual behaviour that occurred in February (2014), and while the policy notes: Disclosure will be made in a timely manner, ideally within 24 hours of the event occurring or of the harm or error being recognised; information reviewed around this serious incident suggests around 72 hours lapsed before family were informed. Interview with the caregivers and registered nurse/manager demonstrate a different understanding of who informs family following an incident. Clarifying responsibility, timeframes, and recording of family notification following incidents is an area for improvement.

Finding:

There is an open disclosure policy that describes the process of family notification following resident incidents. Interview with staff suggests clarification around process is required. One incident (March 2014) that resulted in skin tears following a fall was traced back to the resident file, while the incident was recorded there was no record that family were informed.

Corrective Action:

Clarify responsibility in respect of family notification following resident incidents, and ensure notification is documented.

Timeframe (days): 60 (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:

There are human resources policies to guide practice. An orientation programme is in place. Caregivers are medication competent (link 1.3.12). The caregivers could describe the orientation process. The caregivers state that the orientation includes reading of all policies and procedures and buddying with a caregiver for at least two days. There is a very low turnover of caregivers and a new staff member is always rostered on with another staff member. On review of the five staff files, relevant documents were evidence and performance appraisals were last completed in 2013. There is an in-service planner with scheduled sessions monthly. Staff are paid to attend and pay records were used to verify attendance during this audit. Discussions with three caregivers indicates there is regular inservice provided. D17.7d: There are implemented competencies for staff related to medication with all relevant caregivers. The registered nurse/manager has a current practicing certificate - sighted.

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): <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: <p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: three caregivers in the morning (for varying times), two during the afternoon and one on night shift (2300-0700). The registered nurse/manager full time five days per week (link 1.2.2). The activities coordinator works a total of 15 hours per week, which is split over mornings and afternoons. The service does not use agency staff and all leave is covered in the rosters reviewed. The GP interviewed confirmed that staffing is appropriate to meet the needs of residents. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time (link 1.3). Residents' files are protected from unauthorised access. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. D7.1 entries are legible, dated and signed by the relevant caregiver and/or registered nurse/manager including designation. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

There is evidence of needs assessor service coordination assessments completed prior to entry. Admissions are timely and in consultation with the referrer, transferring provider, resident (if appropriate) family/whanau or advocate. There is evidence of resident advocacy involved in the entry process for the residents. An information pack includes provision of services for prospective residents. One rest home resident interviewed, recently admitted, stated he was fully informed on the admission process and received all relevant information on the services provided.

D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract for rest home residents.

D14.1: exclusions from the service are included in the admission agreement.

D14.2: the information provided at entry includes examples of how services can be accessed that are not included in the agreement

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

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 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

Advised by the registered nurse/manager and owner that should a resident be declined the referrer would be informed and this will be communicated to the resident/family/whānau in a timely manner. Reasons for declining would be if the person has been assessed at a level of care not provided by Benhaven or there are no beds available

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative 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 1.3.3: 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:

The registered nurse/manager has been with the service for three and a half months. She is not familiar with service documentation. She is undertaking InterRAI training in the next week and will be supported by an ex DHB InterRAI project manager to implement the programme at Benhaven.

The registered nurse/manager completes an initial assessment within 24 hours of admission. Information is gathered from the needs assessment, GP letters and medical history, discharge summaries from the district health board and other allied health professionals who have been involved in the care of the resident. The resident and their family/whanau or advocate is involved in the initial plan of care. All the information gathered forms the basis of the initial care plan to guide the care staff and support services in the delivery of a safe care. Residents and four relatives interviewed confirm they were involved in care planning. They were kept informed of health changes and any medical or nursing interventions required in meeting residents health needs.

A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to); continence assessment, Morse falls risk and Norton pressure area assessment. Six of six files did not contain a nutritional assessment on admission and five out of six charts did not evidence a six monthly nutritional assessment and one resident with unintentional weight loss did not have a nutritional assessment completed (link 1.3.4.2). The residents weight, blood pressure, pulse, respiration rate are recorded on admission and completed monthly. The risk tool assessments identify if residents require additional equipment, resources or other allied health professional involvement to meet their assessed needs.

D16.2. 3.4: One (of four) rest home files reviewed identified an assessment was completed within 24 hours and the long term care plan was completed within three weeks. Three residents (rest home) were long term and archived files were not reviewed. There is documented evidence that the care plans were reviewed by a registered nurse/manager. Three of four rest home residents care plans did not evidence evaluations at least six monthly; one was not due for evaluation (link 1.3.8.2). Short term care plans are used for short term needs.

The two young disabled files reviewed showed assessment and long term support plan identified within three weeks of admission and one file did not evidence a six monthly evaluation.

D16.5e: One rest home files (of four) identified that the GP had seen the resident within two working days. Three residents (rest home) were long term and archived files were not reviewed. It was noted in resident files reviewed that the GP has examined the resident at least three monthly. The GP was interviewed and confirmed he visited weekly on Tuesday's for routine visits and will see any resident the registered nurse has concerns about. There is GP cover over the weekends and a locum is provided to cover annual leave. He also meets with the families/whanau to discuss care and treatment options, discuss end of life care and resuscitation status. The GP states he is notified in a timely manner for residents who are unwell by phone or fax. He has confidence in the service and states he feels the staff are doing a good job. The GP has a current practicing certificate and holds a contract for service with the facility.

Tracer Methodology: Rest Home

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

Tracer Methodology – Intellectual Disability

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 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: PA Moderate

Evidence:

The registered nurse develops an initial assessment within 24 hours of the resident's admission. All available information is gathered including NASC assessments, GP medical history and medications, allied health professional records/letters, discharge summaries, specialist letters and information. The resident (if appropriate) and their next of kin/whanau or advocate provides personal information and other details to assist with the initial assessment. The information is used to develop activities of daily living and identify any cultural/spiritual or social needs. The use of assessment tools identifies risk and interventions, equipment and resources required to ensure the safety of the resident. A range of assessment tools are available which include: a) nutritional assessment, b) continence assessment, c) Norton pressure area assessment, d) Morse falls risk, e) pain assessment, f) challenging behaviour assessment. Six of six files did not contain a documented nutritional assessment on admission, five out of six charts did not evidence a six monthly nutritional assessment and a nutritional assessment was not completed for a resident (rest home) with unintentional weight loss. There was no evidence of a pain assessment for one resident (rest home) who is experiencing pain in her knees and has prn medication charted. These are areas requiring improvement. Advance directives and resuscitation is discussed with the GP, resident (if appropriate) and their next of kin/whanau or advocate and registered nurse soon after admission.

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

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

Attainment and Risk: PA Moderate

Evidence:

The registered nurse/manager develops an initial assessment within 24 hours of the resident's admission. All available information is gathered including NASC assessments, GP medical history and medications, allied health professional records/letters, discharge summaries, specialist letters and information. The resident (if appropriate) and their next of kin or advocate provides personal information and other details to assist with the initial assessment. A range of assessment tools are available which include: a) nutritional assessment, b) continence assessment, c) Norton pressure area assessment, d) Morse falls risk, e) pain assessment, f) challenging behaviour assessment.

Finding:

a) Six of six files did not contain a documented nutritional assessment on admission. b) Five out of six charts did not evidence a six monthly nutritional assessment. c) A nutritional assessment was not completed for a resident with unintentional weight loss. d) There was no evidence of a pain assessment for one resident who is experiencing pain in her knees and has prn medication charted.

Corrective Action:

a) Ensure appropriate assessments are completed on admission and at the six monthly reviews; b) Ensure nutritional assessments are completed for those with unintentional weight loss, c) Ensure pain assessments are completed.

Timeframe (days): 60 (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 Low

Evidence:

Long term care plans are developed from assessment information, ongoing collection of information, progress notes, monitoring and observations over a three week period. The long term care plan is resident focused with interventions and goals for each category of care to promote wellbeing and independence. The long-term care plan report includes: cognitive ability; hygiene needs; communication; continence; nutrition; sleep; skin; comfort (including pain management); other needs identify spiritual, emotional and special instructions; safety (mobility aids); medical, medicines use and side effects. The care plans are dated on completion and have a review date. One out of six care plans was not reviewed within given timeframes and one out of six files reviewed did not evidence an activity plan and therefore require improvement. The registered nurse/manager signs the care plan and where able and appropriate the resident and their family/whanau. Residents with no family/whanau have advocates. Short term care plans are used to document any changes in health needs such as infections, reduced mobility, changes in behaviour, pain management with interventions and management. These are kept with the long term care plan in the resident file until. Allied health professionals record their visits in progress notes in the integrated resident file. Caregivers interviewed (three) were kept informed of residents care and health changes and read the care plans. There are good communication channels between the staff and a handover period at the beginning of each shift.

The eight residents and four family/whanau members interviewed confirmed they were involved in all aspects of care planning.

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

D16.3f; Four (of four) rest home files reviewed identified that family/whanau/resident or advocate were involved in care planning as signed on the care plan.

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 Low

Evidence:

Long term care plans are developed from assessment information, ongoing collection of information, progress notes, monitoring and observations over a three week period. The long term care plan is resident focused with interventions and goals for each category of care to promote wellbeing and independence. The care plans are dated on completion and have a review date.

Finding:

a) One care plan was not reviewed within given timeframes. b) One out of six files did not evidence an activity plan

Corrective Action:

a) Ensure care plans are reviewed within given timeframes. b) Ensure all residents have an activity plan.

Timeframe (days): 60 (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: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: PA Moderate
Evidence: Residents' care plans are completed by the registered nurse/manager in conjunction with input from caregivers, the GP, residents and family/whanau members. The care plans record some interventions based on the assessed needs, desired outcomes or goals of the residents. The required clinical care/treatment is recorded, however: five of six files the interventions did not reflect the residents assessed needs eg. Chart one - no interventions for challenging behaviour, pain management or depression; chart two - no interventions for cultural needs, falls (high falls risk), and continence; chart three - no interventions for falls, smoking or challenging behaviour; chart four -no interventions for challenging behaviour and chart five- no interventions for enabler checks. This is an area for improvement. On interview the caregivers were aware of the needs of the residents in their care including strategies to manage challenging behaviour and the minimisation of falls. Weights are recorded on a monthly basis. D18.3 and 4 Dressing supplies are available and a stock of supply is available. On the day of audit, there are no residents requiring wound care. Continence products are available and resident files include a urinary continence assessment, bowel management. Continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Eight residents and four family members interviewed are all complimentary of the care provided at Benhaven. They state that staff are considerate of residents' needs and this was observed by the auditors on the day of audit.

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

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

Attainment and Risk: PA Moderate
Evidence: Residents' care plans are completed by the registered nurse/manager in conjunction with input from caregivers, the GP, residents and family/whanau members. The care

plans record some interventions based on the assessed needs, desired outcomes or goals of the residents. The required clinical care/treatment is recorded. Dressing supplies are available and a stock of supply is available. Continence products are available and resident files include a urinary continence assessment, bowel management. Continence products are identified for day use, night use, and other management. There are no residents with wounds.

Finding:

In five of six files the interventions did not reflect the residents assessed needs.

Corrective Action:

Interventions are recorded that reflect the residents assessed needs.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

There is an activities officer employed for 11.5 hours per week. She is on a ninety day trial period and has been in the position for three months. Currently she works a split shift: 1030 – 1130hrs and 1430 – 1600hours Monday to Friday. She also volunteers her time to take residents to night time concerts. These concerts are included in the activity weekly plan. A monthly activities plan is developed. Daily activity plan is displayed on the white board and residents participate in outings. Attendance is recorded on the daily participation form. Activities program is also provided by the caregivers and caregiving staff is aware of resident’s recreational needs. There are suitable activities available for residents under the age of 65 with trips to the movies, cafes, concerts, social log events and entertainment. A varied and fun exercise programme (as observed) is provided throughout the day with morning and afternoon activities which include exercises, crafts, puzzles, quizzes and dancing. Entertainment is provided and there are weekly van drives in the homes van. Participation is voluntary and confirmed by eight residents interviewed. The residents have three monthly meetings and provide feedback on the programme. Five of six resident files reviewed did not evidence an activity plan (link 1.3.5.2).

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: PA Moderate

Evidence:

Review of five out of six files identified that care plans have not been evaluated by the registered nurse/manager at least six monthly. Five out of six activities plans were not evaluated within given timeframes. This requires improvement. One file was not due for review. There is at least a three monthly review by the medical practitioner including medication reviews. However the medication charts reviewed did not evidence three monthly reviews (link 1.3.12.1).

If the care givers are concerned about a resident they contact the registered nurse/manager who reviews the resident. Evidenced in the progress notes. Medication review showed use of PRN (as required) medication as indicated by the registered nurse/manager is documented in the progress notes. The registered nurse/manager stated that should a resident not respond to current interventions delivered or their health status changes then this is discussed with the GP immediately. GP interview also confirmed appropriate and timely referrals from the registered nurse/manager. Short term care plans are evaluated regularly and signed off when resolved.

ARC: D16.3c: Four (out of four rest home) initial care plans for rest home residents were evaluated by the registered nurse within three weeks of admission

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: PA Moderate

Evidence:

There is at least a three monthly review by the medical practitioner. If the care givers are concerned about a resident they contact the registered nurse/manager who reviews the resident. Evidenced in the progress notes. The registered nurse/manager stated that should a resident not respond to current interventions delivered or their health status changes then this is discussed with the GP immediately. GP interview also confirmed appropriate and timely referrals from the registered nurse/manager.

Finding:

Five out of six care plans and five out of six activity plans were not evaluated within given timeframes.

Corrective Action:

Ensure all care plans and activity plans are evaluated within given timeframes.

Timeframe (days): 60 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA
Evidence: <p>The registered nurse/manager assessments identify the need for a referral to specialist or allied health professionals to meet the resident's needs and goals. The GP initiates referrals as required through the district health board or privately in consultation with the residents, family/whanau/advocates. There was evidence of referrals to physiotherapist, podiatrist, continence specialist, urology clinic, radiology, mental health services for the older person, and breast screen central. D16.4c; The policy is to involve the needs assessment coordination team for re-assessment where a higher level of care is identified. D 20.1 Discussions with the registered nurse/manager identified that the service has access to allied health professionals as required. The hospice provides support and advice for end of life care and management.</p>

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is a procedure for safe, timely and co-ordinated transfer of residents. Documents are provided to include all information to assist medical teams in a full assessment. A resident file reviewed with a transfer to hospital evidenced appropriate documentation sent to the DHB. There was a discharge summary in the resident file. All appropriate notifications are forwarded to the required departments on admission, transfer and discharge from the facility. Family/whanau contact informing of transfer to hospital is documented.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA High

Evidence:

There are policies and procedures in place for safe medicine management. The registered nurse and senior caregivers who administer medications are competency assessed annually and attend medication education. Medication education was last held March 2013 and scheduled for June 2014 (link 1.2.7). The robotic rolls for resident medications are checked on delivery by the registered nurse who countersigns the pharmacy signature on the residents signing sheet. There is a pharmacy agreement in place. All medications are kept in a locked room and the medication trolley is kept under supervision during medication rounds. The medication drug charts are pharmacy generated with photo ID and document any known allergies. The GP has signed the medication charts correctly. There are no documented three monthly reviews evidenced on twelve out of 12 medication charts. This is an area requiring improvement.

On reviewing the files there is a Benhaven chart that the GP signs for medication review. There are no self-medicating residents. Controlled drug register stocktake is carried out weekly and all medications in the controlled drug safe were correctly labelled for the resident. Two medication competent persons checked out controlled drugs and sign the administration form. All returns were kept in a box in a locked room until collection by pharmacy. All eye drops are dated when opened. Eight out of 12 medication charts reviewed did not give indications for the use of prn medication. Three out of 12 administration charts evidenced transcribing. There is an improvement required around prn medication and transcribing.

The caregiver giving out lunch time medication was observed not checking drugs against the medication chart. On interview the caregiver stated that she had been taught to check drugs against the administration signing sheet obtained from the pharmacy. This requires improvement. One resident from the rest home has been given medication for 11 days when the medication chart does not have it prescribed. The administration sheet has it documented but it does not appear on the medication chart, the medications had been reconciled by the registered nurse (manager). On interview the nurse manager was sure that the resident had been charted the drug but was unable on the day to provide evidence. She has contacted the GP who is to review the resident. This requires improvement.

Twelve medication charts reviewed did not identify that the GP had seen the resident three monthly. 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 High

Evidence:

There are policies and procedures in place for safe medicine management. The registered nurse and senior caregivers who administer medications are competency assessed annually. The robotic rolls for resident medications are checked on delivery by the registered nurse (manager) who countersigns the pharmacy signature on the residents signing sheet. There is a pharmacy agreement in place. All medications are kept in a locked room and the medication trolley is kept under supervision during medication rounds. The medication drug charts are pharmacy generated with photo ID and document any known allergies. The GP has signed the medication charts.

Finding:

a) There are no documented three monthly reviews evidenced on 12 out of 12 medication charts. b) Eight out of 12 medication charts reviewed did not give indications for

the use of prn medication. c) Three out of 12 administration charts evidenced transcribing. d) The caregiver giving out lunch time medication was observed not checking drugs against the medication chart. e) One resident has been given medication (ferrous sulphate) for 11 days when the medication chart does not have it prescribed.

Corrective Action:

a) Ensure three monthly reviews are documented on the medication chart. b) Ensure prn medications give indications for use. c) Ensure that transcribing ceases. d) Ensure that medication is checked against the medication chart before administration. e) Ensure that only prescribed medications are administered.

Timeframe (days): 7 (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): <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: PA Low
Evidence: <p>Benhaven has a small domestic kitchen next to the dining room. Food is served from the kitchen and residents can have a meal in their rooms if they desire. The kitchen and equipment is maintained in a clean manner. Benhaven employs two cooks (with the second due to commence) who cover seven days a week. There is a rotating three weekly summer and winter menu in place. The owner reports a review of the menus by a dietician is due to occur. Resident's individual dietary needs are identified, and documented (link 1.3.4.2). Residents special dietary needs are written on the white board and likes and dislikes are catered for. Special equipment is available as needed. Residents are offered fluids throughout the day and additional snacks are available for residents such as sandwiches, biscuits and bread. Residents files sampled demonstrate regular monitoring of individual resident's weight with exception of one file. (Link 1.3.4.2). Residents interviewed were very complimentary of the food service provided and report their individual preferences are well catered for. Fridge temperatures are monitored, the 'milk' fridge has recorded 50 degrees Fahrenheit (10 degrees Celsius) in January, March and April; and 48 degrees Fahrenheit in May; and this is an area of improvement.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Benhaven has a small domestic kitchen next to the dining room. Food is served from the kitchen and residents can have a meal in their rooms if they desire. The kitchen and equipment is maintained in a clean manner. Benhaven employs two cooks (with the second due to commence) who cover seven days a week. The cook interviewed has had food safety training (August 2012). Residents special dietary needs are written on the white board and likes and dislikes are catered for. Residents interviewed were very complimentary of the food service provided and report their individual preferences are well catered for. Fridge temperatures are monitored, the 'milk' fridge has recorded 50 degrees Fahrenheit (10 degrees Celsius) in January, March and April; and 48 degrees Fahrenheit in May; and this is an area of improvement. The contents of the fridge felt cold.
Finding: One of the fridges has been consistently recording a temperature of between 48 and 50 degrees Fahrenheit.

Corrective Action:

Take corrective action to ensure fridge temperatures are maintained at acceptable levels.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

Chemicals are stored in locked storage area and there are chemical use wall charts and safety data sheets in the kitchen and laundry areas. A chemical spills kit is located in the garage. All general waste is disposed of into wheelies bins for collection. There is an approved biohazard container for the disposal of sharps. There is appropriate protective equipment available. Chemicals are stored in a locked storage area. Jaysol provide chemical use wall charts and safety data sheets which are in the kitchen and laundry areas. A chemical spills kit is located in the garage. All general waste is disposed of into wheelies bins for collection. There is an approved biohazard container for the disposal of sharps. There is appropriate protective equipment available.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used 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>

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

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

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

Attainment and Risk: FA
Evidence:
<p>The facility complies with all applicable legislation codes, standards and regulations. Benhaven has a current building warrant of fitness that is valid to 28/09/2014. The maintenance person works two hours a day Monday to Friday and undertakes reactive and preventative maintenance. All fire safety equipment is checked and current. ADT fire monitoring service is carried out as per fire safety regulations. The external buildings and grounds are well maintained. There are outdoor seating areas with shaded areas provided. The outdoor areas are flat with safe paved areas and footpaths. There is ramp access and handrails. A designated smoking area is provided for residents. The interior is well maintained and welcoming with furnishings selected to meet the consumer group needs and safety. The corridors in all areas are wide and spacious enough to allow residents the freedom to move around the facility with the use of mobility aids. There is adequate space for the use of wheelchairs and walking frames. Safety handrails are in place along the corridors. Staff amenities are available. The carpets and other floor surfaces are well maintained. There is a maintenance plan in place. The maintenance person works two hours a day Monday to Friday and undertakes reactive and preventative maintenance and contacts contractors such as electrician or plumber as required. There is a lifting hoist available for resident use in the event of an emergency or fall. The hoist has had a functional and electrical check in October 2013.</p> <p>D15.3d There are two lounge areas designed so that space and seating arrangements provide for individual and group activities.</p> <p>ARC D15.3; The following equipment is available, pressure relieving resources as assessed, shower chairs, high rise toilet seats, walking frames, lifting hoist.</p>

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are nine bedrooms with a toilet and hand basin and three rooms with hand basin only. Residents in single rooms without hand basins or toilets share the communal facilities. There are two large wheelchair access toilets with hand basins and three shower rooms. Residents are assured privacy when attending to personal hygiene needs. The staff knock on doors before entering and there is a vacant/occupied system for communal toilets and showers. Eight residents interviewed confirmed staff respect their right to privacy.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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: FA

Evidence:

There are two double rooms. One of these rooms are shared the one other has single occupancy. All other rooms are single. There is an in-built wardrobe in each room. The rooms are personalized. There is adequate space for residents who use mobility aids to safely move about in their rooms. Residents interviewed stated they were content with their bedroom space, the communal areas and the environment.

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: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a large lounge which is readily accessible for social interaction, activities and entertainment. There is also a lounge/dining area. A separate conservatory is available as a quiet area for privacy or time with visitors. All seating is suitable and appropriate to the needs of the consumer group. The dining area is large and spacious to safely accommodate the residents at meal times. The dining room is suitable to utilize as an additional activity area. Residents were observed moving safely about the communal areas with their mobility aids (includes the use of an electric wheelchair).
D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to 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.)

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: <p>There are written procedures (Bug Control manual) for all aspects of the cleaning and laundry service. Weekly cleaning schedules are in place. Internal audits are carried out monthly. A cleaner is employed. On the day of audit staff were observed to be compliant in infection control practice. Personal protective equipment was evident and goggles were available in the sluice/laundry room. There is large washing machine in the laundry/sluice room and a dryer in a separate clean linen room. Chemicals are provided by Jaysol and chemical wall charts are in place with safety data sheets readily accessible. The chemicals are stored in a locked cupboard. There is a locked gate at the top of the three steps which lead down to the nurse's office and laundry.</p>

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The service has an approved fire evacuation plan from NZFS dated 1995 and 2001. Fire drill carried out 04/07/2013 and the provider reports they are currently arranging the next drill. It is noted this is outside the six month time frame and is a required improvement. Emergency plans include a disaster plan. There are sufficient supplies of bottled water stored in the shed in the event of an emergency. The facility is part of the Upper Hutt Emergency Preparedness Network (Readynet). There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for more than three days are kept in an external store room and extra blankets are also available. There are a working call bell system that connects to nurse call boards. During the tour of the facility residents were observed to have easy access to the call bells. Residents interviewed stated their bells were answered in a timely manner.
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: PA Low
Evidence: There is a fire service approved evacuation plan, and the last reported fire drill was in 04/07/2013. The provider reports they are currently arranging the next fire drill.
Finding: A fire drill has not been carried out in the last six months (last completed 04/07/2013).
Corrective Action: Complete a fire drill.
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation 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.)

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

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

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

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

The communal areas have large windows and are well designed to allow natural light and sunshine into the rooms. There are doors opening out onto the external courtyards. Each bedroom is situated with an outlook onto gardens. The bedrooms all have an external window to allow adequate natural light into the rooms. The environment is warm and comfortable. There is under floor heating which circulates into the individual bedrooms. The heating is thermostat controlled. There are heating units in the bathrooms. The Vulcan heating unit is also a ventilation unit. The eight residents and four relatives/whanau interviewed confirmed the environment was warm and comfortable.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Documented systems are in place to ensure the use of restraint is actively minimized, and at the time of audit there are no residents using restraints. The registered nurse/manager is the restraint coordinator. There are currently three residents using enablers - two bedrails and one lap belt (these were requested by the residents). Appropriate consents are signed. Staff interviews and staff records evidence guidance has been given on restraint minimization and enabler usage. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers. Enablers are monitored when in use, and use of enablers is evidenced documented in resident's care plans. There are no documented interventions evidenced in the care plan for one resident using bedrails (link 1.3.6.2). The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the files of the three residents with an enabler. Two residents interviewed who use enablers confirmed their use was voluntary and at their request. Staff interviews and staff records evidence guidance has been given on restraint minimisation and enabler usage. Staff education on challenging behaviour management and restraint minimization was conducted on 07-Mar-13 and restraint/enabler education is planned for July 2014.

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

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: Benhaven rest home has an infection control programme that is appropriate for the size, complexity and degree of risk associated with the service. The staff meeting includes infection control and health and safety discussion and reporting of infection control matters and consequent review of the programme. Minutes are available for staff. Regular audits take place that include infection control practices, laundry and cleaning. Annual education is provided for all staff – last delivered May (five attended).

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The RN/manager is designated the role of infection control nurse and delivers the training to staff (link 3.4.1). There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

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 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA
Evidence: There are infection control policies and procedures appropriate to for the size and complexity of the service. D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. There are appropriate policies (last reviewed October 2012). Behaven rest home's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste disposal and sharps and spills management. The facility uses the Bug Control IC manuals.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: PA Low
Evidence: The infection control policy states that the facility is committed to the on-going education of staff and residents. Infection control training is documented and a record of attendance is maintained – last provided May 2014 (five attended). Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. The registered nurse/manger

is the infection control coordinator and she is yet to have relevant training for this portfolio, this is an area for improvement.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: PA Low

Evidence:

The registered nurse/manger is the infection control coordinator and she is yet to have relevant training for this portfolio, this is an area for improvement.

Finding:

The registered nurse/manager who is the infection control coordinator for the facility has not had recent infection control training

Corrective Action:

Attend infection control training appropriate to the size and complexity of the facility.

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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 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:

Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are discussed at staff meetings. Detailed information on the type of infections and treatment are recorded. Resident's infection are identified and recorded. Education on infection control for staff was completed in May 2014. An infection control audit was completed in January 2014 with no corrective actions required.

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.)*