# Tuapeka Community Health Company Limited

## Current Status: 5 May 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Lawrence Rural Health Centre is operated by the Tuapeka Community Health Company Ltd and governed by a Board of Directors. The service provides rest home care level care for up to five residents and medical care in two short-stay beds. On the day of audit there were five rest home residents. The manager has been in the role for 16 months and is supported by the board, two registered nurses and long-standing and experienced care staff. There is an established quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed all 15 shortfalls from the previous certification audit around: admission agreements, advance directives, strategic planning, review of quality plan, documentation of corrective actions, provison of core education, assessment and care planning, activity plans, medication competencies, mainteneace schedule, alternative power source, and review of infection control programme.

This surveillance audit identified no additional shortfalls.

## Audit Summary as at 5 May 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
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|  | 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 5 May 2014

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

### Organisational Management as at 5 May 2014

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 5 May 2014

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 5 May 2014

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

### Restraint Minimisation and Safe Practice as at 5 May 2014

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

### Infection Prevention and Control as at 5 May 2014

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Tuapeka Community Health Company Limited |
| **Certificate name:** | Tuapeka Community Health Company Limited |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Lawrence Rural Health Centre | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 5 May 2014 | **End date:** | 5 May 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 5 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 8 | Total audit hours off site | 6 | Total audit hours | 14 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 6 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 5 | Total number of staff (headcount) | 16 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed |  |

## **Declaration**

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

I confirm that:

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

Dated Wednesday, 4 June 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Lawrence Rural Health Centre is operated by the Tuapeka Community Health Company Ltd and governed by a Board of Directors. The service provides rest home care level care for up to five residents and medical care in two short-stay beds. On the day of audit there were five rest home residents. The manager has been in the role for 16 months and is supported by the board, two registered nurses and long-standing and experienced care staff. There is an established quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.  The service has addressed all 15 shortfalls from the previous certification audit around: admission agreements, advance directives, strategic planning, review of quality plan, documentation of corrective actions, provison of core education, assessment and care planning, activity plans, medication competencies, mainteneace schedule, alternative power source, and review of infection control programme.  This surveillance audit identified no additional shortfalls. |

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| **Outcome 1.1: Consumer Rights** |
| Residents and relatives spoke positively about care provided at the Lawrence Rural Health Centre. Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident and care/medical issues. Complaints processes are implemented. Complaints and concerns are actively managed and well documented. Previous shortfalls have been addressed and monitored by the service relating to advance directives and resident agreements. |

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| **Outcome 1.2: Organisational Management** |
| The service has a strategic, business plan and quality and risk management plan 2014. Key components of the quality management system link to staff meeting. The service is active in analysing data of audits, infections and incidents. Corrective actions are identified and implemented. Previous shortfalls have been addressed and monitored by the service relating to strategic planning, review of quality plan, and documentation of corrective actions. Resident satisfaction survey 2013 has been completed and there are regular resident/relative meetings. 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. Previous shortfalls have been addressed and monitored by the service relating to training of care staff. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Lawrence Rural Health Centre has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning and care plan evaluations. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes and this is noted on a short term care plan. Planned activities are appropriate to the group setting. Previous shortfalls in relation to assessments and care planning and activity planning have been addressed and monitored by the service.  There is an appropriate medicine management system in place. The service has addressed a shortfall from previous audit in relation to competencies of registered nurses. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| All building and plant comply with legislation, the service displays a current building warrant of fitness. Previous shortfalls have been addressed and monitored by the service relating to the documentation of a maintenance schedule and the service having an adequate alternative power source. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. There is one resident currently on the restraint register as using a restraint. Policy states that the use of enablers is voluntary, requested by the resident. Restraint/enabler minimisation and challenging behaviour/de-escalation education has been provided to staff. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control nurse completes a monthly infection summary which is discussed at staff meetings. All infections are recorded as per standard definitions of infections on a monthly summary. Previous shortfall relating to the review of infection control programme for 2013 has been addressed and monitored by the service. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 22 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 56 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Discussions with five residents and two family members stated they were welcomed on admission and were given time and explanation about services, procedures etc.  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 Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is provided to residents on entry. D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. D16.4b Two relatives interviewed stated that they are always informed when their family members health status changes. A review of four incident forms (February –April) noted that in all cases the family have been informed. |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified shortfalls around advanced directives (1.1.10.7) and the admission agreement aligning with the ARC contract. (1.1.10.4). There is a resuscitation policy and resuscitation decision form that is completed appropriately for five out of five residents. The service has made improvements in this area.  D13.1: There were five admission agreements sighted and all five have been signed appropriately by either the resident or family and facility representative. A review of a sample of five files identified that informed consent is collected for photos, health information and outings as part of the admission agreement. The service has made improvements in this area.  D3.1.d: Discussion with two family identified that the service actively involves them in decisions that affect their relatives lives. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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

#### Standard 1.1.13: Complaints Management **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff interviewed are aware of the complaints process and to whom they should direct complaints.  Five residents and two relatives interviewed confirm they are aware of the complaints process and they would feel comfortable lodging a complaint or discussing concerns with the manager if necessary. There is a complaints register which includes relevant information regarding the one complaint for 2014. |

##### **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.

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

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

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

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

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Lawrence rural health centre is owned and governed by the Tuapeka Community Health Company Ltd. The manager of the health centre (which includes a medical centre as well as the medical/aged care facility) reports to the board of directors of the company. The manager has been in the role for 16 months with previous experience as a local business man. He has had experience as a director of the Tuapeka Community Health trust for five years. The manager is supported by a receptionist, two registered nurses and eight care staff. The service provides care for up to five rest home residents with an extra two medical beds used for respite and short stay patients. On the day of audit there were five rest home residents (link 1.2.8.). [The service is also certified for hospital – Geriatric, but does not provide that level of care]. There is a documented Business plan (27/01/14) with a quality and risk plan. This includes the goals; client focused service, provision of effective services, certification and contractual requirements, quality and risk management and continuous improvement. Quality plan 2013 has been reviewed in January 2014. The service has made improvements in this area.  D17.3di: The manager has completed at least eight hours annually of professional development in relation to managing a rest home. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a quality and risk system that includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. The service has policies and procedures and associated implementation systems to provide a good level 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.  There is a documented Business plan (27/01/14) with a quality and risk plan. This includes the goals; client focussed service, provision of effective services, certification and contractual requirements, quality and risk management and continuous improvement. Quality plan 2013 has been reviewed in January 2014. There is an audit schedule that reflects this business plan. Internal audits completed that identify areas of non-compliance are addressed with corrective actions. These are discussed at staff meetings. The service has made improvements in this area.  This data included (but not limited to): a) Incidents and accidents and near misses, b) Infections, c) Complaints and concerns, and d) Hazards. Progress with the quality plan is monitored through management reporting to the board on a monthly basis, three monthly quality meetings, and monthly staff meetings.  There are implemented health and safety policies that include hazard identification.  There is an infection control manual, infection control programme and corresponding policies. There is a restraint minimisation management policy. There is currently one resident using restraint.  There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.  There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse and manager who complete the follow up, collate and analyses data to identify trends. Results are discussed with staff through the monthly staff meeting.  All residents and families are surveyed each year (April 2014) as evidenced on review of survey forms and evaluations. Surveys are evaluated and reviews conducted to identify corrective actions. Survey questions include meals, activities, medical and nursing care, privacy and care staff. The service has made improvements in this area. Resident meetings are held quarterly.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident an hazard management D19.2g Falls prevention strategies such as falls assessments, sensor mats, and regular exercise sessions. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service documents and analyses incidents and provides feedback to staff via staff meetings so that improvements are made to the service. Staff can describe the incident reporting process and their role. Four incident forms reviewed for February to April 2014(medication related) included corrective actions and demonstrate the family had been notified, incidents have been discussed at staff meetings, individual staff have been followed up and competencies have been repeated. Staff are aware of the requirement to notify statutory authorities. |

##### **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five files reviewed files (registered nurse, cook, activity officer, and two health centre aides) and all had up to date performance appraisals. Copies of registered health professionals annual practicing certificates are maintained.  The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two health centre aides were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists were evident in staff files reviewed. Discussion with the manager, registered nurse and two health centre aides confirmed that an in-service training programme is in place that covers relevant aspects of care and support and meets ARC requirements. The annual training programme exceeds eight hours annually. Health centre aides have access to on- line training as an additional learning opportunity. The service has made improvements in this area. Five of five staff files include a record of individual training completed. The registered nurses attend external training including conferences, seminars and sessions provided by the local DHB. Both registered nurses are PRIME trained with current certificates. The manager has been a St John ambulance volunteer for 20 years. On review of staff files, performance appraisals have been completed for all five staff. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The staffing policy provides a documented rationale for determining staffing levels and skill mixes for safe service delivery.  The staffing rosters were sighted and there is staff on duty to match the needs of different shifts. The two registered nurses job share across Monday-Sunday and are on call 24/7. The registered nurses (RN) employed by Lawrence Rural Health Centre are "PRIME" trained. There are also two casual RNs that are available should they provide more RN cover with an increase in resident needs ie: end of life. The manager advised that any resident requiring hospital level care is transferred. There is one health centre aide on each shift and the activities person works two hours five days a week.  On audit day there was five rest home residents. The service has a total capacity for five rest home beds and two GP (medical) beds. The two 'medical' beds are used for convalescence, GP outpatient services, locals requiring support post-surgery, or requiring palliative care. These beds are not used for long term residents assessed as requiring hospital level care.  The service has a total of 16 staff in various roles, including manager, two registered nurses, eight health centre aides (all have St John's first aid certificate), two cooks, administrator, activities person, and a cleaner. |

##### **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.

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

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care plans are developed and reviewed / evaluated by registered nurses. Initial assessments and care plans are completed on admission. Long term care plans are developed within three weeks of admission. Residents are seen on admission by general practitioner and reviewed at least three monthly. The service has made improvements in this area. All clinical staff complete progress notes on every shift. Family members are kept informed about the resident's care. The service employs two registered nurses. There is an on call RN cover 24 /7. Five residents interviewed confirm their involvement in the admission process, care planning and evaluation. All five care plans reviewed demonstrate the care plans are developed by the RN, signed off by the resident and/or family member. Family communication is recorded in the residents' file.  Verbal handovers between shifts are conducted. GP was on leave at time of audit however documentation identified daily input from general practitioner. Interventions and treatments prescribed by general practitioner have been completed as evidenced in resident files and interviews with staff, residents and families.   Tracer Methodology:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  D16.2, 3, 4: All five of five rest home long term care residents' files identify that the long term care plan was completed within three weeks of admission. There is documented evidence that the care plan is reviewed by a RN. All five of five rest home long term care residents' care plans evidence evaluations are completed at least six monthly. D16.5e: Resident files reviewed identified that the GP had seen the resident within two working days. |

##### **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.

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

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

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

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

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

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

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

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident files include care needs assessments, completed by NASC team, which are used in establishing a plan of care.  The service completes an initial assessment (on day of entry to the service) and the information gathered at assessment is used to set care plan goals and objectives for residents.  Initial resident assessments are very comprehensive and also include assessment tools; a) pain assessment, b) pressure area assessment, c) falls risk assessment, d) continence assessment and dietary assessment and requirement. This is an improvement from previous audit. GP completes medical admission with two working days and completes medical progress notes. Other service provider’s records; i.e. Physiotherapist are contained in resident files.  Two family members and five residents confirmed their involvement at time of assessment and care planning development and that these assessments are completed in the privacy of the residents bedroom. |

##### **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.

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

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Long term care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Families were supportive of the services provided and the needs of their family member being met. The care being provided is individualised and consistent with the needs of residents as demonstrated by the overview of the care plans and discussion with family, health centre aides, and registered nurse. Interventions are documented to support the resident needs. This is an improvement from previous audit.  Medical and allied health notes were included in the individual file. Activities information is maintained by the activity officer in the resident file. D16.3k: Short term care plans are in use for changes in health status e.g. chest infections, wounds, and urinary infections. D16.3f: Five resident files reviewed identified that family were involved. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' care plans are completed by the registered nurse. Care delivery is recorded and evaluated by health centre aides on each shift (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the registered nurse completes an assessment and general practitioner visits if required. Two health centre aides interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. Five residents and two relatives interviewed were complimentary of care received at the facility. The care plans reviewed included interventions to support the resident needs and had been reviewed six monthly or more frequently if health condition changed.  The care being provided is consistent with the needs of residents, this is evidenced by interviews with two health centre aides, five residents, two relative, and registered nurse. There is a short-term care plan that is used for acute or short-term changes in health status. D16.3f; All resident files reviewed identified that family were involved.  Staff report that there are always adequate continence supplies and dressing supplies.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. On the day of the audit plentiful supplies of these products were sighted. Continence products are available and five of five resident files include a continence assessment.  The registered nurse interviewed described the referral process and associated documentation should they require assistance from a wound care specialist or a continence nurse. Wound assessment and wound management plans are available, currently the service has no wounds. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility employs an activities officer who works for six hours - two hours, five days a week. The activity officer has a Certificate in Human Services and has been employed for six months. Residents' activity assessments are completed in all residents' files reviewed, with care plans developed from information gained from assessment.  A variety of activities are provided that also reflect normal patterns of life, community contact etc. The programme is monitored through residents' and family members' three monthly meetings. A record of attendance in activities is kept and progress notes relating to activities are written. Residents interviewed indicated they found the programme enjoyable. The facility holds a weekly 'Thursday Club' which is open to other members of the community. A van is available for outings. Participation is voluntary and residents are provided with one on one time with the activities officer, if they wish.  Resident satisfaction survey was conducted in April 2014 with very satisfactory results. D16.5d Resident files reviewed identified that the individual activity plan is documented and is reviewed at care plan review. This is an improvement from previous audit. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur. There is at least three monthly review by the medical practitioner.  There are short term care plans for acute and short-term issues including: weight management, skin care, infection and wounds. Changes to the long term care plan are made as required and at the six monthly review if required. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated D16.3c: All initial care plans were evaluated by the RN 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP.  Medication charts record prescribed medications by residents’ GP; these are kept in the medication folder. Medication Administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and PRN medication.  Medication fridge’s are monitored daily and recorded weekly. The service has adequate information and supervises the self-administration of medicines. There is one resident who self-medicates her inhalers. Medications are stored in a locked drawer in the resident’s room. Resident has been assessed as competent by registered nurse and general practitioner, with registered nurse completing monthly reviews with resident.  The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents’ medication charts. There is a staff signature identification sheet in the front of the medication folder.  Controlled drugs are stored in a locked safe and cupboard inside the locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly and stock take is conducted six monthly. There is currently no resident receiving controlled medication. Lawrence rural health uses the blister pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy.  All staff (including registered nurses) performing medication administration receive training on medicine management policies and procedures. Medicine management in-service was provided 15 April 2014. The service has made improvements in this area. D16.5.e.i.2; Five medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

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

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

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

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented food policies/procedures for food service. The service provides Meals on Wheels to the Community. Resident's individual dietary needs are identified and kept in kitchen for reference. Interview with cook confirmed that the kitchen is informed of any changes in resident dietary needs, including special diets. Food in the kitchen and storage areas are dated, labelled and rotated. Food in the fridges and freezers are stored correctly, dated and covered. Fridge and freezer temperatures are checked and recorded. Plated food temperatures are monitored daily.  Visual inspection evidences staff wear protective clothing and the kitchen environment is clean and tidy.  Residents interviewed were satisfied with the food service, report their individual preferences are met and adequate food and fluids are provided. Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight.  Staff interview and staff files evidence that all kitchen and care staff who prepare food have received food safety training -25 Novemeber 2013. This is an improvement from previous audit. |

##### **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.

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

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

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

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

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

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

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Lawrence rural health centre has a current building certificate that expires on 13 December 2014. There is a planned maintenance schedule. The service has made improvements in this area.  Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. Mobility equipment is checked annually-28/6/13. The service has a maintenance book which identified that maintenance is carried out. |

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

All buildings, plant, and equipment comply with legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Hot water temperatures are checked monthly and are within a range of 41-43 degrees Celsius. There was evidence of plumber involvement if temperatures are recorded above 45 degrees. The service has made improvements in this area.  Communal toilet/shower/bathing facilities have equipment/accessories with impermeable surfaces that can be cleaned thus preventing the risk of infection to residents. The service has made improvements in this area. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Alternative cooking facility is available via a gas BBQ. A battery backup is available to provide emergency lighting for 6 hours. A large generator has been purchased since previous audit and will provide power for the entire facility for all electrical requirements including electricity to medical equipment, cooking and heating. This is an improvement since previous audit. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service identifies enablers as equipment, devices, furniture that is used by the resident, following assessment, to promote independence, comfort and/or safety e.g. Bed sides to assist resident's mobility in bed or a tray in front of the table to allow the resident to eat independently. Restraint is overseen by the registered nurse. There is one resident requiring usage of restraint (bedrails and lap belt when sitting in chair) currently residing at Lawrence Rural Health Centre. The service has documented assessment, consent, monitoring and evaluation of restraint. In-service has been provided to staff in relation to restraint minimisation, challenging behavior and de-escalation techniques 21 November 2103. |

##### **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.

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

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

#### Standard 3.1: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified improvements were required in relation to the annual review of the infection control programme. The service has reviewed the 2013 Infection control programme January 2014. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance is an integral part of the infection control programme and infection control policy.  Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly management meetings, and monthly staff meetings. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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