

Scovan Healthcare Limited - Alexander House

Current Status: 20 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

Alexander House provides care up to 21 residents and one of these is allocated for respite care. On the day of audit, they were 21 residents. Alexander House has been owned and operated by the current owner for the past seven years. The owner is a registered nurse and she is supported by another registered nurse who is employed for 16 hours a week. The one shortfall from the previous audit has been addressed, this was around infection control surveillance. This audit has identified improvements required around infection control documentation, staff training, medication management documentation, pain assessments, neurological observations and kitchen bench repairs.

Audit Summary as at 20 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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 20 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 20 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 low risk.
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Continuum of Service Delivery as at 20 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 low risk.
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Safe and Appropriate Environment as at 20 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 20 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 20 May 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Scovan Healthcare Limited
Certificate name:	Scovan Healthcare Limited - Alexander House
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Alexander House
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 May 2014 End date: 20 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:	21
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Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	3
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	16	Total audit hours off site	8	Total audit hours	24
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Number of residents interviewed	7	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	15	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:

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 Monday, 16 June 2014

Executive Summary of Audit

General Overview

Alexander House provides care up to 21 residents and one of these beds is allocated for respite care. On the day of audit, they were 21 residents and one was receiving respite care. Alexander House has been owned and operated by the current owner for the past seven years. The owner is a registered nurse and she is supported by another registered nurse who is employed for 16 hours a week. The one shortfall from the previous audit has been addressed, this was around infection control surveillance. This audit has identified improvements required around infection control documentation, staff training, medication management documentation, pain assessments, neurological observations and kitchen bench repairs.

Outcome 1.1: Consumer Rights

There is an open disclosure policy which describes ways that full information is provided to residents and families. Family members stated that they are always informed when their family member's health status changes. Staff interviewed confirm that open disclosure principles are implemented, there are complaint policies and procedures. Residents and their family/whanau are provided with information on the complaints process on admission. Complaints are recorded in a complaints folder. Staff are aware of the complaints procedure and who to direct complaints to. The complaints log includes name of complainant, date received, nature of complaint, and if the complaint was resolved/advocacy services accessed. The logs for minor and major complaints are separated. The complaint folder includes documentation around investigation, time lines, and response letters.

Outcome 1.2: Organisational Management

There is a 2014-2016 business plan that includes goals, key objectives, strategic direction, quality improvement and risk management plan. The previous two year strategic plan is implemented and reviewed by the manager/owner. There is regular monitoring of progress towards the service's goals. Alexandra House continues to implement its quality and risk management system. Key components of the quality system link to service delivery. Quality data is reported at the quality and staff meetings and meeting minutes include discussions relating to the components of the quality and risk activities. Resident meetings are held six weekly and minutes are maintained. Resident survey was last completed in 2012 and the most recent surveys have been given to the relatives. Internal audits are completed by the owner/manager. There is an evidence of quality improvement plans/action plans being developed when quality activities identify areas for improvement. There are implemented health and safety policies that include hazard identification. A review of the documentation indicates that maintenance issues and hazards are resolved promptly. There is a two yearly staff training programme that is implemented with the exception of restraint and enabler training. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

Alexandra House continue to implements a fall prevention program. Falls prevention strategies include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. The accident/incidents are reported and follow up is completed by the RN and the manager/owner. Corrective actions are identified and these are followed through to ensure implementation. The reporting system is integrated into the quality risk management system. Incidents are analysed on a two monthly basis and discussed at the staff meetings.

There are comprehensive human resource/ management policies. These policies are implemented and staff files reviewed evidenced completed reference checks, job descriptions, evidence of orientation, training, employment agreements and annual appraisals. Staff and residents interviewed report that staffing levels are sufficient.

Outcome 1.3: Continuum of Service Delivery

The manager/owner and the registered nurse is responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, goals have been identified in the long term lifestyle plans and these are reviewed least six monthly. There is evidence in the resident files that there is resident/ family/whanau and caregiver input into the six monthly reviews. There is an improvement required around pain assessments and neurological observations. Resident files are integrated and include notes by the GP and allied health professionals.

Medication education is provided annually for all staff responsible for administration of medicines. Caregivers have completed annual competencies. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities. There is an improvement required around medication documentation.

Food services and all meals are provided on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene. There is an improvement required to bench upgrades.

Outcome 1.4: Safe and Appropriate Environment

Alexander House rest home has a current building warrant of fitness. The environment is homely and comfortable. There is a planned maintenance programme. There is adequate room for residents to move freely about the home using mobility aids. Outdoor areas are readily accessible and safe. There is outdoor seating and shade. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule.

Outcome 2: Restraint Minimisation and Safe Practice

There is restraint policy which has clear guidelines to determine what a restraint is and what is an enabler. Interviews with staff confirmed their understanding of enablers. There is currently no enablers or restraint in use at Alexander House.

Outcome 3: Infection Prevention and Control

The registered nurse is the infection control co-ordinator who is responsible for ensuring effective monitoring/surveillance of infections. Infection control surveillance is integral to the quality and risk management programme. Monthly infection control data is collected for all infections. All infections are entered on to an infection control data sheet. This is an improvement since the previous audit. Infection control data is discussed at the three monthly staff and quality meetings. There is an annual infection control report that includes review of infection control data and infection control issues. The audit identified an improvement required around documentation of infection control surveillance.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	11	0	5	0	0	0
Criteria	0	35	0	5	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	61

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource	Human resource management processes are	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	conducted in accordance with good employment practice and meet the requirements of legislation.				
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The restraint minimisation training and enablers training was last completed in January 2012.	Ensure that regular staff training around restraint minimisation and enablers occurs.	180
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 Low			
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 Low	i) One resident who was experiencing pain did not have a pain assessment completed. ii) One resident who had experienced a fall with a knock to the head did not have neurological observations completed.	i) Ensure pain assessments are completed for residents experiencing pain. ii) Ensure neurological observations are completed for residents who have a knock to the head.	60
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	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		guidelines.				
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 Low	i) Seven out of ten medication charts did not have indications for prn medication use. ii) Six out of ten medication charts reviewed did not document a three monthly medication review.	i) Ensure medication charts have three monthly reviews documented. ii) Ensure that prn medications have indications for use documented.	90
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 legislation, and guidelines.	PA Low	There were noted chips off the kitchen bench, advised there are plans to renovate the kitchen.	Ensure upgrades occur as planned	180
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low			
HDS(IPC)S.2008	Criterion 3.5.7	Results of surveillance, conclusions, and specific recommendations to assist	PA Low	The April 2013 monthly infection control summary	Ensure that infection control summary form is fully completed and	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.		sheet showed that monthly infection control summary form is not fully completed and outcome of infection control activities are not documented.	outcome of infection control activities are documented and acted upon.	

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

The open disclosure policy recognises residents and their families have a right to full and frank disclosure of information and staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Incident forms reviewed for December- January (nine) identified that family were notified.

Families/whanau often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

Two relatives and seven residents interviewed stated that staff and the manager/owner are approachable, friendly and highly regarded by families/whanau. In-service education around communication and open disclosure occurred in May 2013.

Resident meetings occur six weekly and the manager/owner has an open-door policy.

D16.4b Two family/whanau members interviewed stated that they are always informed when their family members health status changes.

D12.1 Non-Subsidised residents/EPOA 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.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There are complaint policies and procedures and residents and their family/whanau are provided with information on the complaints process on admission. Complaints are recorded in a complaints folder.</p> <p>Staff are aware of the complaints procedure and who to direct complaints to. The complaints process is in a format that is easily followed.</p> <p>Two family/whanau members and seven residents interviewed confirm that they are aware of the complaints process and they would make a complaint if necessary.</p> <p>The complaint log includes name of complainant, date received, nature of complaint, and if the complaint was resolved/advocacy services accessed. The logs for minor and major complaints are separated.</p> <p>Since January 2013, there have been four complaints recorded on the register and noted as minor complaints. All complaints are investigated and a documented follow-up is attached. The major complaints log includes two complaints that were lodged to the Health and Disability Commissioner (HDC). The complaint folder includes documentation around investigation, time lines, and response letters to the HDC. The complaint is continuing to be investigated.</p>

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Alexander House provides care for up to 21 residents and one of these beds is allocated for respite care. On the day of audit, they were 21 residents and one was receiving respite care. Alexander House has been owned and operated by the current owner for the past seven years. The owner is a registered nurse (RN) and she is supported by another RN who works 16 hours a week. Job descriptions for the manager/owner and the RN outline their authority, accountability and responsibility. Both the manager/owner and the RN have completed on-going training appropriate to their position. The owner stated that she has increased the RN cover in Alexander House to 16 hours a week.

There is a 2014-2016 business plan that includes goals, key objectives, strategic direction, quality improvement and risk management plan. The previous two year strategic plan is implemented and reviewed by the owner/ manager. There is regular monitoring of progress towards the service's goals. The manager/owner has maintained at least eight hours of professional development activities annually related to managing a rest home.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Standard 1.2.3: 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: <p>Alexandra House continues to implement its quality and risk management system. Key components of the quality system link to service delivery. Quality data is reported at the risk management meetings and discussions with the manager/owner and two caregivers, one cook and review of meeting minutes demonstrate their involvement in quality and risk activities. Staff meetings includes discussions relating to the components of the quality and risk activities.</p> <p>Resident meetings are held six weekly, and minutes are maintained. Resident survey was last completed in 2012 and the most recent surveys have been posted to the relatives. The last survey results shows satisfaction with the services provided.</p> <p>The manager/owner manages the quality systems. There is a quality team which includes staff. The team conducts a quality meeting three monthly, and all aspect of the quality system are discussed in this meeting. The management meeting agenda includes (but not limited to); incident accidents, complaints, falls, hazard, audits, restraint, staff training, maintenance, challenging behaviour, staffing, infection control and the social program.</p> <p>Quality data is also discussed in the staff meetings (three monthly), and minutes are maintained and kept in the staff reading folder as well as meeting minutes' folder.</p> <p>Audits are completed by the manager/owner. There is an evidence of quality improvement plans/action plans being developed when quality activities identify</p>

areas for improvement. Examples include staff training is completed following an infectious outbreak and fire training is repeated when new staff were non-compliant. Two caregivers interviewed stated that audit results are communicated to staff and required corrective actions are completed. The internal audit programme includes but not limited to; building compliance (February 2014), care plan audit (February 2014), residents admission procedure (May 2014), recreation (June 2014), residents care (May 2013), health and safety (December 2013), staff training (December 2013), restraint (April 2014) and behaviour management (April 2014). There are corrective action plans and resolutions to any issues found. Such as following a health and safety audit, electrical testing was re-completed.

There is a document control system. All policies include the date, the policy was last reviewed. Documents no longer relevant to the service are removed and archived. There is a staff folder that kept on the staff desk for easy access to more relevant policies. Discussion with two caregivers confirmed that they are familiar with the policies and procedures and they can access to all policies and procedures easily.

D19.3. There are implemented health and safety policies that include hazard identification. A review of the documentation indicates that maintenance issues and hazards are resolved promptly. Hazard register is up to date and the last hazard audit was completed in October 2013.

There is a two yearly staff training programme that is implemented with the exception of restraint and enabler training (link 1.2.7.5).

D5.4: . The service has the following policies/ procedures to support service delivery. The manager/owner stated that Vitamin D program is still supported by the GPs. Part of this program, staff completed systems that support the provision of clinical care and support including care planning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The manager/owner stated that Vitamin D program is still supported by the GPs. As part of this program, staff completed systems that support the provision of clinical care and support including care planning.

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 and a restraint policy and health and safety policies and procedures.

D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Alexandra House continues to implement a falls prevention program, education on risk factors to identify high risk residents, and implementation of preventable measures. Two caregivers interviewed are knowledgeable around their responsibilities and around residents' training on how to involve them in preventing themselves falling, such as using the call bell system, using their walkers, and being more actively involved with exercises to improve strength.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The accident/incidents are reported and follow up is completed by the RN and the manager/owner. Corrective actions are identified and these are followed through to ensure implementation. The reporting system is integrated into the quality risk management system. Incidents are analysed on a two monthly basis and discussed at the staff meetings.</p> <p>December 2013 to January 2014 accident and incident reports are reviewed. Review of the nine reports revealed that family members have been informed of an incident/accident. Required immediate actions were noted and any follow up action were completed by manager/owner. Minutes of the staff meetings reflect a discussion of incidents/accidents and actions taken. Six out of nine accident/incident reports are related to a fall incident, and subsequently required interventions around falls prevention are included in the resident's care plan as required.</p> <p>Two family members interviewed stated that they are kept fully informed. Although all accident/incidents forms reviewed demonstrated that there was clinical follow up by the RN or and the manager/owner, one of the files reviewed showed that one resident who had experienced a fall with a knock to the head did</p>

not have neurological observations completed (link1.3.6.1). In all cases where it is appropriate, contact with families after an incident/accident is documented either on the incident/accident form or in progress notes.

Staff interview (two caregivers and a cook) confirm that staff are familiar with the incident/accident reporting process and described discussion of these at the staff meeting. Discussions with the manager /owner confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications, and stated that the DHB was notified about the complaint to the HDC. Document review showed that an infectious outbreak was notified to the public health services in 2014. The outbreak log is sighted.

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.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

Timeframe (days): (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: PA Low

Evidence:

Alexandra House employs a total of 15 permanent staff. There are human resource policies and procedures in place for staff recruitment, training and support. Six staff files were reviewed (one registered nurse, one cook, and four caregivers). The manager/owner conducts annual performance appraisals, and all files reviewed have up to date performance appraisals. The recruitment and staff selection process is implemented, and relevant checks are completed to validate the individual's qualifications and experience. Reference checks are completed before employment is offered and are evident in all six staff files reviewed. Two out of six files had signed employment agreements and four staff files reviewed were under collective employment agreement, and a copy of a contract was not in the file.

The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed describe the orientation process, and stated that they believed new staff are adequately orientated to the service. There are completed orientation documents in all files reviewed.

Alexandra house does not have a dementia unit. However, aging process and dementia care training was provided to staff in May 2013 and 9 staff participated to this training.

There is a two yearly staff training program and there is documented evidence that staff has access to internal and external training opportunities. ACE training is supported by Alexandra House for caregiving staff. Medication competencies are completed for staff who administer medication. These are checked by the manager/owner or the RN. The training plan is implemented with the exception of restraint minimisation and enablers training. This is an area requiring improvement.

The RN and the owner /manager attend external training including seminars, training programs that were provided by the local hospice and sessions by the local DHB.

D17.7d: There are implemented competencies for staff related to medication with all relevant caregivers completing these annually.

The registered nurse and the RN/manager/owner have a current practicing certificate. A copy of visiting practitioner's certification including GP, pharmacist and physiotherapist is maintained.

D17.8 Eight hours of staff development or in-service education has been provided annually.

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

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

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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: PA Low
Evidence: There is a two yearly training plan that links to all aspects of the DHB contract. Some trainings are provided through external specialists such as palliative care and infection control. Training records for six of six staff members indicate that they attend all programmes.
Finding: The restraint minimisation training and enablers training was last completed in January 2012.
Corrective Action: Ensure that regular staff training around restraint minimisation and enablers occurs.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staffing policy is implemented. The manager/owner or the registered nurse is on-call at all times.

The manager/owner works 28- 32 hours per week. The RN works 16 hours per week.

The roster is as follows:

Rest home occupancy 21 residents

Manager/owner (Mon,Tues,Thurs and Fri) 8:30-16:30, and on-call,
1xRN (2 days a week) 8:00-16:00, and on-call when required.

Am - 1x caregiver- 07:00-15:00), 1x caregiver/cleaner 07:00-11.45).

Pm - 1x caregiver15.00-23.00 1xcaregiver 16:00-20:00).

Night - 1xcaregiver 23:00-07:00).

1x cook- 7-13.30

1 x activities co-ordinator (Mon-Fri 25 hours a week).

1 x maintenance person (co-owner) -as required.

Physio services are provided by external provider.

Staff interviews confirm that staffing level is adequate.

Residents interviewed (seven) stated that staff are busy at times but their needs are met. Families/whanau interviewed reported that staffing is adequate and the owner /manager is always available.

Acuity of residents at the time of audit is particularly low with no significant events. Staff interview confirm that resident requiring palliative care is supported by the manager/owner. Auditors observed that residents received required support during the mid-day meal.

Laundry services are completed by care giving staff throughout the day. - no changes from the previous audit. Staff leave work late, come early (it was always part of the work schedule) ensuring that handover is given to the coming shift. Staff interview confirmed this occur.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c.i; 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: D.16.2, 3, 4: The five rest home resident files sampled identifies the RN or the owner/manager completes an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial care plan. Five resident files sampled identified that the long-term resident lifestyle care plan is developed within three weeks. There is documented evidence of care plan reviews held six monthly involving the resident/family/whanau, RN and care staff. The RN or the owner/manager amends the long term support plan to reflect on-going changes as part of the review process. If allied health professionals are involved in the resident’s care they maintain progress notes in the integrated resident files. All five resident files sampled had details around family contacts and the information discussed documented in the significant notes.

D16.5e: Five of five resident files sampled identified that the GP had seen the resident within two working days. It was noted in five of five resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in the file of a palliative care resident with more complex needs. The GP was available as required for the resident for palliative care. The RN assessment and request for GP intervention is appropriate. There is a handover period between the shifts to ensure staff are kept informed of residents' health status and any significant events. Caregivers write progress notes each shift. The RN and owner /manager reviews the notes and reports on any resident significant events. The podiatrist visits six weekly.

Tracer methodology

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>The service provides services for residents requiring rest home level care. Care plans are completed comprehensively. Five resident files, were reviewed for this audit: palliative care, wound, frequent falls, chronic pain (on controlled drugs), new admission. Three out of five care plans evidenced at least a six monthly care plan review. Two not due for review. One resident who was experiencing pain did not have a pain assessment completed. This is an area for improvement. Short term care plans are available for use. Short term care plans are well used. One</p>

resident who had experienced a fall with a knock to the head did not have neurological observations completed. An improvement is required. Care being provided is consistent with the needs of resident's; this is evidenced by discussions with two caregivers, two family/whanau members, and one manager/owner. Residents' needs are assessed prior to admission and resident's primary care is provided by their own GP. There is evidence of referrals to specialist services such as podiatry, hospice, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and there are stocks available for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

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

A wound assessment, evaluation and wound management plan including timeframes for review is in place for one resident with a wound. On interview the manager/owner stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There have been no wound specialist referrals at this time.

The GP was unavailable for interview.

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 Low
Evidence: The service provides services for residents requiring rest home level care. Care plans are completed comprehensively. Short term care plans are available for use. Care being provided is consistent with the needs of resident's; this is evidenced by discussions with two caregivers, two family/whanau members, and one manager/owner.
Finding: i) One resident who was experiencing pain did not have a pain assessment completed. ii) One resident who had experienced a fall with a knock to the head did not have neurological observations completed.
Corrective Action: i) Ensure pain assessments are completed for residents experiencing pain. ii) Ensure neurological observations are completed for residents who have a knock to the head.
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: <p>There is an activities coordinator who is responsible for activities, identifying different needs that are appropriate to their age culture and differing health status. The activities coordinator is employed for 25 hours over five days per week and has been with the service 12 years. The activity plan is developed on admission to the service identifying special needs, their likes/dislikes and past hobbies are discussed with the resident and family/whanau where appropriate and noted on their care plans. There are a range of activities offered, that reflect resident's needs. Participation in activities is voluntary. Residents are able to have input into the activities programmes via suggestions made at residents meetings.</p> <p>The activities coordinator described a comprehensive activities programme that involves residents in the community. The activities provided are age appropriate and well attended by residents.</p> <p>Activities include (but are not limited to) senior citizens club, music club, gardening, trips to special events in the community, church service and art/painting. There are three visits to town a month and a library visit for those who wish to go. A monthly plan is developed and a record of what activity individual residents have done each day is maintained. Participation is voluntary and this was confirmed by the seven residents interviewed.</p> <p>Seven residents and two relatives/whanau interviewed commented the activities programme was excellent.</p> <p>D16.5d: Resident files (five) reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.</p>

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Evaluations occur six monthly by the registered nurses with input from the GP and the activities coordinator. Relatives/whanau are notified of changes in a resident's condition evidenced by seven of seven residents interviewed and the two family/whanau members interviewed. Caregivers write in residents' progress notes on each shift and document any changes in care/condition of residents. Risk tool assessments are reviewed at least six monthly. Evaluation forms follow the support need categories listed on the long term care plan. There is evidence of the resident/family/whanau involvement in the care plan review. Short term support plans are reviewed regularly with problems resolved or added to the long term support plan if an on-going problem. The GP conducts a three monthly resident review of weight, blood test results, mobility and health status and medication review. The RN reviews the long-term care plan at the same time as the activity care plan.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. Three of five care plans had been evaluated six monthly. Two were not due.

ARC 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>There are appropriate and up to date policies and procedures for rest home level medication management including appropriate safe storage facilities. Medications are stored in a locked room in a medication trolley. Medications prescribing and administration is safely managed. Staff have been trained in safe medication administration. Staff medication competencies are carried out annually. The service retains a record of the medication competency and these are on staff files and up to date. Last completed October 2013. There is a current specimen signing sheet.</p> <p>The facility uses the medication management system Douglas Medico that is delivered in four week supply. Medication education was held in June 2013. Medications are prescribed by the residents GP, on a medication prescribing sheet. Medication charts are legible. Ten medication charts were reviewed for this audit. All had photo ID, and appropriate signing by the administering care staff with sample signatures available on all files. Medications are checked in by the RN or the manager/owner and signed as correct on the blister packs. Any errors are reported back to the pharmacy. There are currently no residents self-medicating.</p> <p>There is appropriate storage and recording for controlled drugs with one resident on controlled drugs currently in use. Weekly controlled drug checks are completed. The medications are administered by the medication competent care givers or RN's. Allergies are recorded in the resident's file and on the drug</p>

administration records. The service has an incident/accident form for the reporting of all adverse reactions and errors. Seven out of ten medication charts did not have indications for prn medication use. An improvement is required.
D16.5.e.i.2; Six out of ten medication charts reviewed did not document a three monthly medication review. This requires improvement. All the medication charts were 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 Low

Evidence:

There are appropriate and up to date policies and procedures for rest home level medication management including appropriate safe storage facilities. Medications prescribing and administration is safely managed. Staff have been trained in safe medication administration. Staff medication competencies are carried out annually. Medications are prescribed by the residents GP, on a medication prescribing sheet. Medication charts are legible. There is appropriate storage and recording for controlled drugs

Finding:

i) Seven out of ten medication charts did not have indications for prn medication use. li) Six out of ten medication charts reviewed did not document a three monthly medication review.

Corrective Action:

- i) Ensure medication charts have three monthly reviews documented.
- ii) Ensure that prn medications have indications for use documented.

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

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

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

Attainment and Risk: FA

Evidence:

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The kitchen is a small homely kitchen. There are plans to update the kitchen facilities. The kitchen was observed to be clean and well kept. There are two cooks who work on a four on four off roster. Caregivers manage tea. Fridge, freezer, and meat temperatures are monitored weekly and documented (sighted). Hot food temperatures are monitored.

All food in the fridge is covered and dated. The meat for the day is sighted stored at the bottom of the fridge. The menu was reviewed by a dietitian in 2012. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. The resident likes and dislikes are known to the caregivers and cook. The nutritional profile is reviewed six monthly as part of the care plan review. The services advised they can access a registered dietician for input into the provision of special menus and diets, where required. Residents with special dietary needs have these needs identified in their care plans. The main meal is at midday. Residents have alternative choices offered. Festive occasions are celebrated and resident choose the menu for their birthday. Two families/whanau and seven residents interviewed expressed satisfaction with the meals.

D19.2: Staff have been trained by Eco Lab in safe food handling.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The kitchen is a small homely kitchen. There are plans to update the kitchen facilities. The kitchen was observed to be clean and well kept. There are two cooks who work on a four on four off roster. Caregivers manage tea. Fridge, freezer, and meat temperatures are monitored weekly and documented (sighted). Hot food temperatures are monitored

Finding:

There were noted chips off the kitchen bench, advised there are plans to renovate the kitchen.

Corrective Action:

Ensure upgrades occur as planned

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The building has a current warrant of fitness which expires 1 August 2014. There is a planned maintenance programme. There is a communication book used for the daily maintenance requests. Maintenance is provided by the co- owner and in most cases the issue can be repaired or resolved on the same day. External contractors are engaged to complete work as required. The manager/owner co-ordinates and authorizes the contractors to carry maintenance requests. Corrective actions are documented in the communication book. The manager/owner is available on call for urgent matters. Electrical equipment has been tested and tagged. Hot water temperature monitoring is completed monthly with readings within acceptable ranges. A hot water temperature audit was conducted in February 2014. The interior of the home is well maintained and homely. There is a separate dining area and two lounges. There are call bells in all communal areas, toilets, bathrooms and residents rooms, including the lounge. Residents are observed to be moving freely around the facility with the use of mobility aids. There is easy access to the outdoor areas and gardens. Ramps and rails lead to the outdoor area. There is outdoor seating and shade in place. The grounds and garden are well maintained. There is a specific outdoor smoking area.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: There is a restraint policy which has clear guidelines to determine what a restraint is and what is an enabler. Definition of restraint and enablers which is congruent with the definition in NZS 8134.0. Interviews with staff (two caregivers and one cook) confirmed their understanding of enablers. There is currently

no enablers or restraint in use at Alexander House.

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:

Ensure that staff receive training around use of enablers.

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

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

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: PA Low

Evidence:

Monthly infection control data is collected for all infections. All infections are entered on to an infection control data sheet. This is an improvement since the previous audit. Infection control data is discussed at the three monthly staff and quality meetings. Review of meeting minutes revealed that infection risk is

identified if apparent and minimisation or prevention strategies are then planned and implemented. Staff interviews (two caregivers and one cook) evidence compliance.

Infection control audits are included on the annual audit schedule and the last infection control audit was completed in February 2014. There is annual infection control report that includes review of infection control data and infection control issues.

The registered nurse is the infection control co-ordinator who is responsible for ensuring effective monitoring/surveillance of infections. Infection control surveillance is integral to the quality and risk management programme. Definitions of infections are in place that are appropriate to the complexity of service provided. These are described in the infection control programme. The audit identified an improvement required around documentation of infection control surveillance.

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

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: PA Low
Evidence: Document review and staff interview evidenced that an infectious outbreak with symptoms of diarrhoea and vomiting occurred between 9 March and 20 March 2014. Three staff and 10 residents were affected. Notification to public health services occurred and infection outbreak log was maintained. During this process the manager/owner had been in touch with infection control specialists and expert advice, and support were obtained. Document review showed that outbreak evaluation form was completed and subsequently, infection control practices are reviewed and staff training was re-completed. Staff interview

(two caregivers and one cook) confirmed that these occurred. Each resident has an individual infection report that includes reporting on skin, eye, urinary, respiratory, and gastrointestinal and other infections that may be identified. April 2014 infection control data sheets were reviewed.

Finding:

The April 2013 monthly infection control summary sheet showed that monthly infection control summary form is not fully completed and outcome of infection control activities are not documented.

Corrective Action:

Ensure that infection control summary form is fully completed and outcome of infection control activities are documented and acted upon.

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