

Ohope Beach Care Limited

Current Status: 9 June 2014

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

This audit was conducted to assess the provider's readiness to extend the number of dementia beds from 17 to 25. The proposed increase in capacity required a new extension to the current building. On the day of the audit there were eight residents requiring rest home level care and 20 residents requiring secure dementia level care. Five of the residents requiring dementia level care were already residing in the new dementia wing.

There was evidence that some improvements have been implemented following previous audits, however a number require further corrective actions. These include improvements regarding medical reviews on admission, progress notes, completion of assessments, recording of evaluations, development of short term care plans and improvements to the medicines management system.

An additional five areas requiring improvement were identified. These included additional improvements to the medicine management system (including competencies), ensuring all bedrooms in the new extension provide sufficient space to manoeuvre and reviewing of the infection control programme to ensure it is sufficient to accommodate the extension and increase in capacity.

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:	Ohope Beach Care Limited		
Certificate name:	Ohope Beach Care Limited		
Designated Auditing Agency:	HealthShare Limited		
Types of audit:	Partial Provisional Audit		
Premises audited:	Ohope Beach Care		
Services audited:	Rest home care (including dementia care)		
Dates of audit:	Start date: 9 June 2014	End date: 10 June 2014	
Proposed changes to current services (if any):	Extension of existing building to increase capacity from 17 dementia beds to 25 dementia beds		
Total beds occupied across all premises included in the audit on the first day of the audit:	28		

Audit Team

Lead Auditor	XXXXX	Hours on site	14	Hours off site	12
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	4

Sample Totals

Total audit hours on site	14	Total audit hours off site	16	Total audit hours	30
Number of residents interviewed		Number of staff interviewed	5	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	29	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

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

I confirm that:

a)	I am a delegated authority of HealthShare Limited	Yes
b)	HealthShare Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	HealthShare Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	HealthShare Limited has provided all the information that is relevant to the audit	Yes
h)	HealthShare Limited has finished editing the document.	Yes

Dated Tuesday, 8 July 2014

Executive Summary of Audit

General Overview

This audit was conducted to assess the provider's readiness to extend the number of dementia beds from 17 to 25. The proposed increase in capacity required a new extension to the current building. On the day of the audit there were eight residents requiring rest home level care and 20 residents requiring secure dementia level care. Five of the residents requiring dementia level care were already residing in the new dementia wing.

There was evidence that some improvements have been implemented following previous audits, however a number require further corrective actions. These include improvements regarding medical reviews on admission, progress notes, completion of assessments, recording of evaluations, development of short term care plans and improvements to the medicines management system.

An additional five areas requiring improvement were identified. These included additional improvements to the medicine management system (including competencies), ensuring all bedrooms in the new extension provide sufficient space to manoeuvre and reviewing of the infection control programme to ensure it is sufficient to accommodate the extension and increase in capacity.

Outcome 1.1: Consumer Rights

Outcome 1.2: Organisational Management

Day to day operations were the responsibility of the manager. The manager had sufficient skills and experience. The manager reported to the owner who owned two other rest homes. The clinical manager had a bachelor of nursing and was required to oversee all clinical activities. The clinical manager has had no specific training in dementia since registration in 2009 and an improvement is required. The clinical manager was absent during the audit, for an unspecified time, however a replacement registered nurse was contracted the day after the audit.

Human resources were sufficient to accommodate current services and the increase in capacity. There were written policies and procedures in relation to human resource management which complied with current good employment practice. The skills and knowledge required for each position was documented and the required recruitment checks were conducted. Caregivers had experience in care of the older person and working with residents with dementia. New staff received an orientation to the facility and on-going inservice training was provided. Additions had been made to the roster to accommodate the increase in bed numbers.

Outcome 1.3: Continuum of Service Delivery

Although there had been some progress towards addressing previous areas of improvement further corrective actions were still required. Areas requiring continued improvement included medical reviews on admission, progress notes, completion of assessments, recording of evaluations, development of short term care plans and improvements to the medicines management system. Additional improvements to the medication management system were also identified.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.2: Service Management	The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	PA Low			
HDS(C)S.2008	Criterion 1.2.2.1	During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	PA Low	The clinical manager has had no dementia specific training since registration.	Provide evidence that the clinical manager had completed dementia training.	180
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The previous improvement regarding time frames for medical reviews following admission has not been sufficiently addressed.	Provide evidence that all residents have a medical assessment within the required timeframe, regardless of whether the resident was a previous respite admission.	90
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA High	Progress notes are insufficiently documented. ii) Resident records are not integrated.	Discontinue the use of a separate communication book for progress reporting. (i) Integrate records.	7
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	PA Low	The required assessments are not	Provide evidence that the required assessments are	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		sighted in one out of seven records sampled.	documented on admission.	
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Level of achievement and progress towards goals has not been documented during the review/evaluation process.	Include level of achievement and progress towards goals in the review/evaluation process.	90
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	The use of short term care plans has not been clearly defined within the documented policies and procedures.	Define the use of short term care plans within the documented policies and procedures.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	Medicine management does not meet requirements.	Provide evidence that medicine management meets requirements as identified in the finding and that all previous findings have been sufficiently addressed.	7
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they	PA Moderate	The clinical manager has not completed a medication competency. (ii) Competency when	Provide evidence that the clinical manager has completed a medication competency. (ii) Ensure all	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		manage.		administering medications is not observed during the audit.	health care assistants are competent to administer medication.	
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA High	There is insufficient evidence that the general practitioner has assessed or approved a resident's safety or competency to self-administer medications.	Provide evidence that the resident can safely self-administer medications.	7
HDS(C)S.2008	Standard 1.4.4: Personal Space/Bed Areas	Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	PA Low			
HDS(C)S.2008	Criterion 1.4.4.1	Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely manoeuvre with the assistance of their aid within their personal space/bed area.	PA Low	Adequate space has not been provided in room B of the new extension.	Reconfigure the lay out of room B of the new extension to ensure the resident can safely move around the bed and access the drawers and hand basin.	Prior to occupancy
HDS(IPC)S.2008	Standard 3.1: Infection control management	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.	PA Low			
HDS(IPC)S.2008	Criterion 3.1.3	The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The infection control programme has not been reviewed to reflect the new extension noting that the infection control coordinator was not	Provide evidence that the infection control coordinator has reviewed the new build to ensure that the infection control programme includes the additional service.	Prior to occupancy

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				consulted during the planning phase of the new build.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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:

Day to day operations is the responsibility of the manager. The manager is on site five days per week. The manager is not a health professional, however has gained experience relevant to the aged care sector, and is able to show evidence of maintaining at least eight hours annually of professional development activities related to aged care. This includes attendance at the 2013 gerontology conference. The manager is also a career force assessor and an emergency medical technician for St Johns Ambulance. The manager has been in the role since 2006 and is able to describe the role. The manager's curriculum vitae and job description is sighted and confirms accountabilities, authorities and responsibilities. The manager reports to the owner who owns two other rest homes. The owner is interviewed by phone and states they receive the required reports.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a delegated person who can fulfil the manager's position in a temporary absence. This person has a background in administration and a letter confirming this agreement is sighted (dated January 2013).

The clinical manager has a bachelor of nursing and is required to oversee all clinical activities. The clinical manager has had no specific training in dementia since registration in 2009 and an improvement is required. The clinical manager has had a recent injury and has been absent from work. A replacement has not been identified and a high risk was allocated. Following the audit the lead auditor received confirmation that a registered nurse from a bureau had been contracted and had started at the service the following day. The registered nurse will be required to complete assessments, care plans, reviews and oversee medicines management. The Ministry of Health and the District Health Board were informed of the change and the initial partial achievement with corresponding high risk was removed.

The clinical manager's job description confirms responsibilities and delegations. The clinical manager is on call 24 hours a day, seven days per week.

The District Health Board requirements are partially met.

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

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

Attainment and Risk: PA Low

Evidence:

A clinical manager is employed. The clinical manager has a bachelor of nursing (2009) and is employed to be on site five days per week and on call twenty-four hours a day, seven days per week. The clinical manager's curriculum vitae is sampled and it is noted that, since registration, the clinical manager has had no dementia specific training and an improvement is required.

The District Health Board and Ministry of Health are notified of this shortfall during the audit.

Finding:

The clinical manager has had no dementia specific training since registration.

Corrective Action:

Provide evidence that the clinical manager had completed dementia training.

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

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

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

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

Attainment and Risk: FA

Evidence:

There are written policies and procedures in relation to human resource management which comply with current good employment practice. Staff files are sampled. The sample is stratified and includes both clinical and non-clinical staff.

The skills and knowledge required for each position within the service is documented in job descriptions which outline responsibilities. The provider has commenced police checking of all new staff (as required in a previous audit) and evidence of police checks are sighted. Caregivers are required to have experience in care of the older person and there is a system for the validation of professional qualifications. For example all caregivers have the required national certificate and dementia series for caregivers and the annual practising certificate for the clinical manager.

All new staff members receive an orientation to the facility and to their respective job. The orientation programme includes the essential components of service delivery, including emergency procedures. Orientation checklists for new staff are sighted and the newest employee confirms the orientation process.

There is a planned programme of on-going education. A training planner is developed annually which includes the required mandatory training. The clinical manager conducts the in-service training. Individual training records and attendance records are maintained. Training records of permanent night staff are included in the sample and confirm attendance at required training, for example fire evacuation drills.

Performance is monitored and an annual appraisal is completed for all staff. These are up to date and sighted in the files sampled.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>The facility employs 29 staff in total. This includes one clinical manager, caregivers, an activities person and maintenance/domestic staff. The provider refers to the staffing regulations for aged care facilities (Ministry of Health) for determining service provider levels and skill mix. There is also a policy titled 'skill mix'.</p> <p>The current roster is sampled. The staffing level reflects the number and mix of residents, acuity of residents, residents care levels, lay out of facility, staff skills and experience. The appropriate skill mix for caregivers is reflected on the roster and this is checked to confirm the required training, education and first aid requirements.</p> <p>There are three staff on the floor during the morning, two in the afternoon and two at night. In addition the number of staff on site during the afternoon shift has been increased to reflect the additional residents due to the extension. The additional shifts include two four hour shifts: one shift from 1530 hours to 1930 hours and another from 1630 hours to 2030 hours. This provides additional cover during the evening meal and when the residents with dementia can tend to be unsettled. Designated laundry staff have also been appointed. Caregivers can attend to residents needs and cares without having to attend to additional domestic duties. The clinical manager is (normally) on the floor from 8am to 4.30pm Monday to Friday and the principle caregiver is on the floor three days per week and works as a personal assistant to the clinical manager two days per week.</p> <p>It is noted during the audit that staff spend the majority of their day in the dementia area and attend to rest home residents if required. Rest home residents are observed to be independently coming and going and are sighted being appropriately supported with activities and at meal time. There is an allocated and rostered caregiver in the rest home who completes all required tasks and is able to help in the dementia unit if required.</p> <p>The clinical manager on the day of the audit is temporarily not able to be on call. This was addressed on the day after the audit with confirmation from the owner that a</p>

replacement registered nurse has been contracted.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The previous improvements regarding the time frame for completing medical reviews following admission, integration of records and recording of progress notes have not been sufficiently addressed. The remaining improvement regarding family contact has been sufficiently addressed.

The District Health Board requirement has not been meet.

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: PA Low

Evidence:

Seven residents' records are sampled. This includes rest home and hospital residents. The sample includes two recent admissions to the dementia unit. These are reviewed for initial general practitioner visits. Both residents have previously stayed at Ohope Beach Care receiving respite services. One had been seen by the general practitioner within two working days; however there was a delay with the other resident due to a change in general practitioner. The resident was admitted on 25 May 2014 and the medical assessment was completed on the 4 June 2014. Records sampled confirm that the delay was discussed with the family member whilst waiting for approval to change general practitioners.

Finding:

The previous improvement regarding time frames for medical reviews following admission has not been sufficiently addressed.

Corrective Action:

Provide evidence that all residents have a medical assessment within the required timeframe, regardless of whether the resident was a previous respite admission.

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

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

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

Attainment and Risk: PA High

Evidence:

The previous finding regarding progress notes has not been sufficiently addressed. Although activities of daily living plans and progress notes are contained in the one folder, full details of the residents' day to day concerns including those which require follow up by the clinical manager, are being documented in a communication book and are not documented in the residents' file/progress notes. The communication book is an exercise book, is not stored securely and entries do not comply with health records standards and privacy requirements. Resident records in the communication book are sampled and confirm that clinical details are being left off the progress notes. This includes recordings of observations, responses to treatment, early signs of infection, variations in behaviour and incidents. Staff report that the communication book is utilised so that the clinical manager is made aware of residents who have 'current' issues. The principle caregiver prepares a hand over report for all staff to refer to during hand over between shifts. This is sampled and confirms appropriate information is being communicated between caregivers. It is reported that the clinical manager does not always attend hand over reports.

The previous improvement regarding family input has been adequately addressed. Family contact sheets are maintained and three family interviewed report they are very satisfied with the service and always contacted in a timely manner.

Finding:

(i) Progress notes are insufficiently documented. ii) Resident records are not integrated.

Corrective Action:

i) Discontinue the use of a separate communication book for progress reporting. (i) Integrate records.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The previous improvement regarding the use of risk assessments has not been sufficiently addressed, however, some improvement has been made and the associated risk level has been re-assessed as a low risk.

The District Health Board requirements have been partially met.

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:

Completed risk assessments sighted with the resident file sample include pain, quality of life, nutrition, pressure, falls, mental assessment and continence. These are consistently sighted and demonstrate an improvement from the last audits. Where required, pain assessments accompany those who are on pain relief medication and falls preventions plans are documented where a high falls risk is identified. However, the records of the most recently admitted resident has not had assessments documented.

Note: the resident was admitted as a permanent placement on a day that coincided with the absence of the clinical manager.

Finding:

The required assessments are not sighted in one out of seven records sampled.

Corrective Action:

Provide evidence that the required assessments are documented on admission.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The previous improvements regarding the ongoing evaluation of care plans, review of goals and short term care plans has not been sufficiently addressed, however, some improvement have been made and the associated risk level has been re-assessed as a low risk.

The District Health Board requirement has been partially met.

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

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

Attainment and Risk: PA Low

Evidence:

A new evaluation form was developed following the last audit and this is sighted in resident files sampled. All files sampled have had a review within the required timeframe and two provide evidence that they have been completed with a family member; however the level of achievement and progress towards goals has not been documented on the review form. The risk level is reassessed as a low risk.

Finding:

Level of achievement and progress towards goals has not been documented during the review/evaluation process.

Corrective Action:

Include level of achievement and progress towards goals in the review/evaluation process.

Timeframe (days): 90 (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: PA Low

Evidence:

There remains insufficient evidence that short term care plans are being documented when a change occurs. Wound care plans are sighted and two short term care plans are viewed. One is for a resident with XXXXX (as a result of antibiotics treatment) and the other is for a resident who has had fracture, however short term plans are not

being documented for all events that exceed routine cares, for example infections. Staff are interviewed and there is some confusion regarding when short term care plans should be documented. The use of short term care plans has not been clearly defined within the documented policies and procedures. The risk level is reassessed as a low risk.

Finding:

The use of short term care plans has not been clearly defined within the documented policies and procedures.

Corrective Action:

Define the use of short term care plans within the documented policies and procedures.

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

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

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

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

Attainment and Risk: PA High

Evidence:

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice guidelines. A blister pack medication system is implemented. All medicines are prescribed by the general practitioner using the pharmacy generated medication chart. Each medication is individually signed and dated/signed when a change occurs. The service has one general practitioner.

Fourteen medication charts are sampled. All medication charts include photo identification and allergies. Three monthly general practitioner reviews are evident. Administration charts have been maintained.

Medications are safely stored in a locked medication cabinet in the nurses' station. There are no standing orders and all medications are individually prescribed.

The previous improvements identified have not been sufficiently addressed and a number of additional improvements are required. These relate to stores, labelling, transcribing, administration, competencies and self administration.

The District Health Board requirements have not been met

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

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

Attainment and Risk: PA High
Evidence: Medicine management does not meet requirements and not all of the previous findings have been sufficiently addressed. The previous findings were in regard to (i) maintaining bulk supplies, (ii) the controlled drug register and (iii) medication fridge temperatures. (i) The medication cupboard is sighted and there remains a large amount of unpackaged medication. This includes liquids, inhalers and 'as required' medication. The auditor is advised that the medication has been delivered in the morning and therefore there are large supplies. All medication sighted is individually labelled. (ii) There are no controlled drugs and the controlled drug book reflects the same. (iii) Medication has been removed from the food fridge; however the temperature of the designated medication fridge has not been consistently documented and/or recorded. In addition, the following areas require improvement. (i) Medication has been dispensed into an unlabelled bottle and a staff member has hand written a label, including name of medication, dose and frequency. This medication is found on the current medication trolley. (ii) A staff member has changed the prescribed instructions on the label of a bottle of medication. The label has been changed from 'take one tablet at 4pm' to 'take one additional dose prn'. (iii) One diabetic resident is prescribed 26 units of insulin per day at breakfast. The label on the insulin package states 20 units per day. The insulin is being given after breakfast every day. The clinical manager is phoned and reports that the general practitioner is satisfied with the insulin being given after breakfast as long as the resident takes the insulin regularly every day. (iv) One medication signing chart has been fully transcribed by a staff member including both regular and non-regular medications. (v) One resident is prescribed XXXXXX and is being administered XXXXX. The supply of XXXXX came from the resident's home supply. (vi) Specimen signatures are not maintained for the regular general practitioner and any visiting general practitioners.
Finding: Medicine management does not meet requirements.
Corrective Action: Provide evidence that medicine management meets requirements as identified in the finding and that all previous findings have been sufficiently addressed.
Timeframe (days): 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate
Evidence: A medication competency process is in place. Competencies are conducted annually and are signed off by the clinical nurse manager; however the clinical manager has not completed a competency since employment. Medicine administration is observed. (i) the staff member is observed signing the administration chart prior to administering the medication. (ii) the staff member is observed placing an antibiotic straight into her hand rather than into a dispensing cup or into the resident's hand. (iii) the staff did not wash her hands between attending to each resident
Finding: (i) The clinical manager has not completed a medication competency. (ii) Competency when administering medications is not observed during the audit.
Corrective Action: (i) Provide evidence that the clinical manager has completed a medication competency. (ii) Ensure all health care assistants are competent to administer medication.
Timeframe (days): 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA High
Evidence: The previous area requiring improvement to the self administration process has not been sufficiently addressed. One rest home resident continues to self-medicate. Blister packs are stored securely in the resident's room. Following the previous audit consent was signed by the resident (November 2012) stating they accept responsibility for the safety of their medication. A self-medication assessment is also sighted. The self-medication assessment has been reviewed by the clinical manager in May and November 2013 and May 2014, however there is no evidence that the general practitioner has assessed or approved the resident's competence or safety to do so. The consent and the assessment have not been signed by the general practitioner.
Finding: There is insufficient evidence that the general practitioner has assessed or approved a resident's safety or competency to self-administer medications.
Corrective Action: Provide evidence that the resident can safely self-administer medications.
Timeframe (days): 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Residents are provided with a well-balanced diet which meets their nutritional needs. There is a winter and summer menu and it is reported that the menu is reviewed by a registered dietician to confirm it is appropriate for the nutritional needs of the older person.</p> <p>Nutritional assessments are completed on entry. These are sighted in resident records sampled. Special dietary needs are identified.</p> <p>Residents are weighed monthly and records confirm nutritional needs are being sufficiently addressed. Where required, additional nutritional support is documented and appropriate interventions implemented. The general practitioner reviews weight charts during routine medical reviews. Residents in the dementia area have access to snacks throughout the day and the new dementia area has been fitted with a kitchenette.</p> <p>Meal time is observed during the audit. The dining room in the dementia area has been extended and care staff are observed supporting residents with meals. There is an adequate number of staff available during meals, with the recent addition of extra staff during the evening meal.</p> <p>The cook has the required food safety qualification and confirms that the expected increase in resident numbers will not impact on the current provision of food services. The size of the kitchen has been increased and new equipment purchased. The kitchen and pantry are sighted and are clean, well-stocked and tidy. Labels and dates are on all containers and temperature monitoring is maintained.</p> <p>The District Health Board requirements are met.</p>

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There are sufficient processes regarding the management of waste and hazardous substances to accommodate the new facility and the expected increase in resident numbers. Hazardous substances include chemicals and blood/body contaminants. Domestic rubbish is picked up by the council. There are spill kits and sharps containers provided.</p> <p>Policies require a hazardous substances register to be maintained and regular assessments on the use of hazardous substances to be conducted. These are sighted.</p> <p>Cleaning chemicals are provided by an external provider and dispensed in the close chemical system. Chemicals in bottles are labelled and kept secure. Material safety data sheets are sighted and there is adequate protective equipment and clothing on site.</p> <p>The external chemical provider provides training to staff on the management of hazardous substances and this is scheduled to be provided again in July 2014. Laundry staff are orientated to the use of chemicals during orientation.</p>

There have been no reported incidents/accidents regarding waste or hazardous substances.

The District Health Board requirement is met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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 required checks and compliance requirements are in place for the existing building which includes the rest home wing and existing secure dementia wing. This includes a current building warrant of fitness (expires October 2014), approved fire evacuation scheme, ongoing maintenance of grounds and equipment. The original building is a single level Lockwood design. There are evenly surfaced pathways, external seating and garden areas. There is adequate parking. Buildings, facilities, furnishings, equipment and medical devices are well maintained and suitable for the care and support of elderly residents. Calibration records are sighted and electrical equipment is tagged. There is adequate furniture and equipment throughout. Residents are transported safely in the van. Health and safety inspections of the facility are undertaken on a regular basis and a hazard register is documented.

The new extension has been added to the current dementia wing. The renovation commenced June 2013 and was finished March 2014. As well as an additional nine bed rooms the new extension includes a small laundry, adequately sized family room, separate toilet and combined toilet and wet area/shower. Additional renovations have also been made to increase the size of the existing lounge/dining area and the kitchen. Three secure outdoor areas have also been developed. Newly purchased furniture includes new hospital beds and 10 new lazy boy chairs.

The provider is already using the new wing and there are five bedrooms currently in use. The required code of compliance and district health board requirements had not been met prior to the audit, however corrective actions made during and immediately after the audit were approved by the District Health Board and the Ministry of Health was informed. This included a copy of the Code of Compliance. The improvement required (identified initially as a high risk) is no longer required.

The District Health Board requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

The facility has sufficient bathrooms and toilets in all areas (rest home and dementia). There are designated staff and visitor facilities. There are adequate areas for staff to wash their hands and alcohol gel is sighted throughout the facility. Hot water is monitored. The hot water checks are sighted. The new dementia wing has solar panels and records sighted confirm the water is maintained at a consistent temperature.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

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

Attainment and Risk: PA Low

Evidence:

Resident rooms in the existing areas are of adequate size and allow for the safe use and manoeuvring of mobility aids, however there is one room in the new extension (room B) which does not allow for the resident to move around the bed or access the drawers and hand basin. This is due to the placement of the built in furniture. The resident has dementia and it is reported that the resident does not use the drawers or hand basin.

Residents are able to bring their own possessions into the facility and decorate their bedrooms as desired.

The District Health Board requirements are met.

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

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

Attainment and Risk: PA Low

Evidence:

The layout of built- in furniture in room B of the new extension does not allow the resident to safely move around the personal bed area and access drawers or the hand basin. This was also mentioned by a visiting family member.

Finding:

Adequate space has not been provided in room B of the new extension.

Corrective Action:

Reconfigure the lay out of room B of the new extension to ensure the resident can safely move around the bed and access the drawers and hand basin.

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There are two open plan lounges and a dining area in both the rest home and the dementia area. Group entertainment and activities are conducted in both rest home and dementia lounges. Dining areas are adequate in size. Furniture in communal areas is currently arranged to ensure residents are able to move freely and safely. Seating is adequate and appropriate. Furniture and fittings are appropriate and minimise the risk of falls from trip hazards. Hallways in all areas are wide enough to accommodate mobility aids and equipment is safely stored. The entire facility is well decorated, homely and colourful.

There is a small communal room in the new extension which can be used by family and/or a quiet room.

The District Health Board requirements are met.

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

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Cleaning and laundry services meet infection control requirements and are of an appropriate standard. All laundry is laundered on site and the laundry has good separation of clean and dirty areas. There is an additional laundry in the new extension which has one washing machine and one dryer.

The main laundry equipment is well maintained and sufficient to cope with the volumes. Day to day cleaning and laundry requirements are completed by the designated laundry staff. A well-equipped, and secure, cleaning cupboard is provided and this is where the bulk of chemicals are stored.

Staff members are trained at orientation in the use of equipment and chemicals and the chemical provider provides additional training. Documented guidelines are available.

Cleanliness, linen and laundry standards are monitored through regular internal audits, resident and family surveys and resident meetings. The most recent audit was conducted in May 2014 and confirms that standards are being maintained.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. There are security cameras throughout the building and additional cameras will be placed in the new extension. Accessible call bells are displayed throughout. These are checked by the auditor at random and confirm that call bells are in working order. There are well stocked supplies and emergency plans in the event of emergencies. The emergency management and business and continuity plan is sighted as is the emergency back pack and first aid supplies. There is a staff member with current first aid training on each shift and staff members receive training in the management of emergencies in orientation and thereafter six monthly in fire evacuation training/drills.</p> <p>The fire service approved the original evacuation plan (2002), however a current approval which includes the new extension is not sighted, however a New Zealand Fire Service evacuation scheme was provided to the auditor two days after the site visit. The improvement required (identified initially as a high risk) is no longer required.</p> <p>Biannual fire drills are sighted. The most recent fire evacuation was conducted April 2014 (this was attended by eight staff, including night staff).</p> <p>The District Health Board requirements are met.</p>

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

The facility has plenty of natural light. All rooms have at least one good sized window for natural light. There is plenty of natural light and ventilation. The facility has adequate methods for maintaining a consistent temperature through the use of electric heating in each room. The whole site is a dedicated non-smoking area.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: PA Low

Evidence:

The infection control programme has been documented for the existing rest home and dementia unit, however the extension and current requirements are not included to date and the infection control coordinator has not been consulted regarding the new build.

The clinical manager is the designated infection control coordinator and the infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. This is provided on induction and is sighted on the mandatory in-service programme.

Infection control is included in monthly staff meetings. Information on infection control prevention and control activities is displayed and communicated. This includes hand washing reminders and information to visitors and residents regarding reducing the spread of infection.

Policies and procedures include hand washing, cleaning and sterilisation, standard precautions, isolation, outbreak management, management of staff with infections, health and safety, and a list of notifiable diseases.

The District Health Board requirements are partially met.

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: The infection control programme is documented for the previous configuration of services (rest home and initial dementia unit).The programme has not been extended to include the extension and additional numbers of residents. The infection control coordinator is interviewed and reports they were not consulted regarding the new build.
Finding: The infection control programme has not been reviewed to reflect the new extension noting that the infection control coordinator was not consulted during the planning phase of the new build.
Corrective Action: Provide evidence that the infection control coordinator has reviewed the new build to ensure that the infection control programme includes the additional service.
Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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: Not Audited
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>