Wyndham and Districts Community Rest Home Incorporated

Current Status: 8 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

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract. Wyndham rest home provides care for up to 23 residents at rest home level of care. There were 18 residents residing at the facility on audit day.

Areas identified as requiring improvement at the last certification audit around the development of a risk management plan, documentation of monthly evaluation of activities, staff designation entries in progress notes, integration of residents' files and recording of allergies on medication charts are met. One previous area requiring improvement around staff medication competencies remains.

There are areas identified at this surveillance audit that require improvement around staff education, adverse events, human resources, care plans and risk assessments and medication management system.

Audit Summary as at 8 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 8 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.

Organisational Management as at 8 May 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Continuum of Service Delivery as at 8 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Safe and Appropriate Environment as at 8 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.

Restraint Minimisation and Safe Practice as at 8 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.

Infection Prevention and Control as at 8 May 2014

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

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:	Wyndham and Districts Community Rest Home Incorporated
Certificate name:	Wyndham and Districts Community Rest Home Incorporated

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Surveillance Audit			
Premises audited:	Wyndham and Districts Community Rest Home			
Services audited:	Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	8 May 2014	**End date:**	8 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:	18

Audit Team

Lead Auditor	XXXXXX	**Hours on site**	9.5	**Hours off site**	4
Other Auditors	XXXXX	**Total hours on site**	9.5	**Total hours off site**	4
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	19	Total audit hours off site	10	Total audit hours	29

Number of residents interviewed	5	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	30	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Tuesday, 20 May 2014

Executive Summary of Audit

General Overview
This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract. Wyndham rest home provides care for up to 23 residents at rest home level of care. There were 18 residents residing at the facility on audit day. Areas identified as requiring improvement at the last certification audit around the development of a risk management plan, documentation of monthly evaluation of activities, staff designation entries in progress notes, integration of residents' files and recording of allergies on medication charts are met. One previous area requiring improvement around staff medication competencies remains. There are areas identified at this surveillance audit that require improvement around staff education, adverse events, human resources, care plans and risk assessments and medication management system.

Outcome 1.1: Consumer Rights
There is an open disclosure policy. Interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed at the facility. Staff, residents and family interviewed demonstrate an understanding of the complaints process. A complaints register is maintained and up to date.

Outcome 1.2: Organisational Management
Wyndham rest home is operated as an incorporated society with board members from the local community. There are systems in place which define the scope, direction and goals of the facility, and there are monitoring and reporting processes against these systems. Quality improvement data are reported monthly to the governing body. Monitoring and communication of quality improvement data occurs via facility meetings. Internal audits are conducted and where corrective actions are required this is documented, implemented and there is evidence of completion. Resident and family interviews confirm satisfaction with services provided. Wyndham rest home is managed by a nurse manager, a registered nurse with aged care experience. The adverse event reporting system documents adverse, unplanned or untoward events. There is evidence in the residents' files reviewed of adverse event forms and monthly reports relating to adverse events. There is an area requiring improvement around adverse events being communicated to family and neurological observations to be conducted when this is required following an adverse event. There is an in-service education and training opportunities provided for staff. There are areas requiring improvement around staff education and adherence to human resource management systems.

There is a documented rationale for determining staff levels and staff skill mixes and there is evidence this is being adhered to.

Outcome 1.3: Continuum of Service Delivery

Service provision is undertaken by suitably qualified and experienced staff. The service is coordinated in a manner that promotes continuity in service delivery through the use of progress notes, diaries, and 'weekend handover' notes.
Resident files reviewed do not have care plans that are reviewed six monthly. Although risk assessments are completed by the service the resident who's' care is reviewed does not have risk assessments completed to reflect current abilities or needs.
Consultation and liaison with other services occurs. The care plans record interventions based on the assessed needs. Family members interviewed confirm they are satisfied with the care and treatment at the facility.
Family and staff interviews confirm the activities are appropriate. Not all residents have the new activities assessment completed. The activities programme includes ordinary unplanned or spontaneous activities.
Time frames in relation to care planning evaluation are documented in policies and procedures. There is recorded evidence of input from specialist or multi-disciplinary sources; however multidisciplinary reviews are not current.
The medication room in the facility is appropriate, however the door to the medicines room cannot be locked. Medicines are stored in original dispensed packs. The controlled drug register evidences weekly checks and six monthly physical stocktakes. The morning medication round in the rest home was observed. All staff authorised to administer medicines have current competencies however the registered nurse' (RN) competencies are not signed off by another registered nurse. The service has one RN, an enrolled nurse, and eight care givers who administer medicines.
Medicine charts reviewed do not all have current three monthly reviews completed by the GP. New entries and discontinued medicines recorded on the medicines charts are signed and dated by the GP. Allergies and sensitivities are recorded and all charts have photo identification.
The nurse manager confirms that there is one resident who self-administers medicines. The service monitors the resident however the medicines are not currently kept in locked storage.
The nutritional assessment of residents forms part of the initial nursing assessment. Food services policies and procedures are appropriate to the service setting. There is dietician input into review of residents with weight loss.
The cook monitors fridge and freezer temperatures daily.

Outcome 1.4: Safe and Appropriate Environment

The nurse manager advises there have not been any alterations to the building since the last certification audit. A Building Warrant of Fitness is displayed at the main entrance and expires on 18 July 2014.

Outcome 2: Restraint Minimisation and Safe Practice

The service has one resident utilising restraint and no residents using enablers. There are systems in place to ensure the use of restraint is actively minimized. Staff interviews and records evidence education and training relating to restraint minimisation and safe practice. The service has a risk and quality management system of which restraint forms part of. The service's definitions of restraint and enabler are congruent with the definition in NZS 8134.0. The restraint register is current.

Outcome 3: Infection Prevention and Control
The service completes monthly surveillance of the infections according to the number and type of infection. Specimens are sent for laboratory testing in order to establish sensitivities for prescribing of antibiotics. The infection control policy is reviewed bi-annually. Surveillance data is communicated to the Trust Board and to staff members at the monthly staff meetings. Data is expressed in graphs and pie charts.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	2	3	0	0
Criteria	0	35	0	4	4	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	32
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Adverse events are not consistently communicated to family as evidenced in three of five incident forms, progress notes and family communication forms. Two of five adverse events evidence no neurological observations were completed when this was required. Interview with the nurse manager confirms adverse event resulting in harm to resident (fractured femur) was not reported under Section 31 of the Health and Disability Services (Safety) Act 2001.	Provide evidence adverse events are communicated to family, neurological observations are conducted when required post adverse events and reporting under section 31 of the Health and Disability Services (Safety) Act 2001 occurs when this is required.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The nurse manager's file does not evidence current performance review. Last performance review was conducted in 2012. The nurse manager states there are four registered nurses (RN) who provide weekend on call support for the facility. Reviewing two of two weekend on call RNs staff files evidences both staff files do not have employment contracts, evidence of orientation, job descriptions, peer reviews and competency assessments on files. The nurse manager states all four weekend on call RNs are volunteers and have no contracts, orientation, job descriptions, competencies, performance reviews, however they do receive on call payments.	Provide evidence human resources systems are adhered to.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	There is one care giver that has not completed education related to the care of the older people (ARC D17.6.c) since their employment over a year ago. The facility policy records annual training / education will be conducted in cultural safely, The Code of Rights and restraint, however this has not occurred.	Provide evidence all staff who are in direct contact with residents have completed education that is related to the care of the older people within six months of appointment and the staff education plan provides the required annual education.	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 Moderate			
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 Moderate	i) Four of the five reviewed long term care plans are not current, ii) risk assessments are not current, iii) no evidence of pain assessments being completed for residents who present with pain.	Long term care plans to be current (six monthly reviews), ii) risk assessments to be reviewed in order to update care plans, iii) pain assessments to be completed for residents who present with pain.	180
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The service implemented a new assessment form which is more comprehensive and not all residents have the new assessment completed and resident meeting are not occurring regularly.	All residents to have activities assessments completed and resident meeting to be held regularly.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Moderate			
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 Moderate	Four of the ten files reviewed do not have current three monthly reviews completed by the GP and the door to the medicines room cannot be locked.	All resident who are well deemed well enough in order to be assessed three monthly (rather than monthly) to have three monthly reviews completed by the general practitioner and medicines room to be securely locked.	30
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 manage.	PA Low	The RN's competencies are not currently signed off by another RN and competency testing does not currently include a written questionnaire for staff members to complete. Staff members only complete an observation round with a checklist in order to be deemed competent.	All competencies to be signed off by a registered nurse and staff members to complete written evidence of being competent to administer medicines as well as being observed during the practice of medicines management.	90
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	The medicines are not securely stored.	Medicines used during self-administration of medicines to be kept in secure locked storage.	30

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: There is a policy in place on open disclosure. Residents (five of five) and family members (five of five) interviewed confirm that staff and management communicate well with them. The nurse manager advises there are no residents requiring interpreter services at time of audit. Incident forms, residents' progress notes and family communication forms do not consistently evidence family are informed of adverse events or when resident's condition alters (refer to criterion 1.2.4.3). Related ARC requirement are met.

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

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

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

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)
Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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: The complaints policy and procedures are congruent with Right 10 of the Code of Rights. There is a complaints register which is current and monitored by the nurse manager. Complaints registers for 2013 and 2014 were reviewed. There is evidence that the complaints are actioned according to policy timeframes. Information about the complaints system are communicated in writing to the resident and their family. The complaints process and complaint forms are located at entrance to the facility. The Nationwide Advocacy Service and the HDC contact details are available at the facility. Five of five residents and five of five family members interviewed are aware of the complaints processes. The nurse manager states there has not been any complaints since the last certification audit, referred to the Health and Disability Commission, coroner, police, accident corporation or Ministry of Health. ARC requirements are met.

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

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

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

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 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: The facility is an incorporated society with board members from local community, which currently include registered nurse, farmers and local businesspersons. Interview with the chairman of the board confirms there has not been any change in the membership of the governing body since last certification audit. Facility's mission statement and philosophy are recorded and available to residents and families and referring agencies and staff. There are systems in place which record the scope, direction and goals of the facility. Monthly reports to the board are provided by the nurse manager and include quality and risk management issues, complaints, occupancy, human resource issues, quality improvements, internal audit outcomes, and activities. Board meeting minutes sighted from January 2014 to April 2014. The nurse manager is a registered nurse with current practicing certificate and has been in this position for two and half years. The nurse manager states they are supported in their role by a board member who is a registered nurse, currently practising in DHB. The nurse manager has experience relevant to both management and the health and personal care of older people and is able to show evidence of maintaining at least eight hours annually of professional development activities relating to managing a rest home. Nurse manager's file reviewed. All staff requiring practising certificates have current practising certificates, sighted. Wyndham rest home has contracts with Southland District Heath Board (SDHB) for aged related residential care for rest home services and aged related residential respite care. ARC requirements met.

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

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

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

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

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

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

Standard 1.2.3: 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: There are quality and risk management systems in place, sighted. At last certification audit an area identified as requiring improvement around development of a risk management plan has been met. There is evidence the quality improvement data is collected, collated, evaluated, and analysed to identify trends and if corrective actions are required this is developed and implemented. An internal audit schedule and completed audits for 2013 and 2014 were reviewed. Quality and risk management data and quality improvement data is reported at facility's meetings. Meeting minutes reviewed evidence this. The nurse manager states resident meetings are held six monthly, however last resident meeting minutes are recorded in January 2013 (refer to criterion 1.3.7.1). Policies and procedures reflect current accepted good practice and reference legislative requirements. Staff interviews (three care givers, one enrolled nurse, one activities co-ordinator and one cook) confirm staff are informed of new / updated policies and staff signing sheet demonstrate staff have read and understand the new / reviewed policies. Document control policy and procedure for new or reviewed documents is recorded and implemented. Hazard registers were sighted. Health and safety is discussed at meetings, sighted and evidence discussion and reporting on accident/ incidents; hazards

and maintenance. Sighted graph for hazard reporting from August 2013 to August 2013.

Residents and family satisfaction survey was last conducted in April 2014 and results record high level of satisfaction with the services surveyed and no requirements for corrective action are required. The satisfaction survey questions relate to privacy; dignity and rights; medical services; assistance; cleaning; food; activities; laundry; safety and security and gardening.

ARC requirements are met.

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

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

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

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

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

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

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

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

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

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

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

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 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

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

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

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

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

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: There is an adverse event reporting system in place. All accident/incidents are recorded and reported. Sighted incident analysis summary from August 2012 to August 2013, that includes falls, skin tears, medication errors, missing residents and challenging behaviour. Staff interviews confirm staff are aware of the adverse event reporting system and state all adverse events are reported and recorded. There is an area requiring improvement around communication with families following adverse events, conducting neurological observations when this is required post an adverse event and notification under Section 31 of the Health and Disability Services (Safety) Act 2001 of any incident or situation that puts at risk the health or safety of the residents. Not all ARC requirements are met. Post Audit – the provider and the DAA could not reach agreement in respect of this finding.

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

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

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

Attainment and Risk: PA Moderate
Evidence: There is an adverse event reporting system in place. Sighted incident analysis summary from August 2012 to August 2013. Staff interviews confirm staff are aware of the adverse event reporting system.
Finding: Adverse events are not consistently communicated to family as evidenced in three of five incident forms, progress notes and family communication forms. Two of five adverse events evidence no neurological observations were completed when this was required. Interview with the nurse manager confirms adverse event resulting in harm to resident (fractured femur) was not reported under Section 31 of the Health and Disability Services (Safety) Act 2001.
Corrective Action: Provide evidence adverse events are communicated to family, neurological observations are conducted when required post adverse events and reporting under section 31 of the Health and Disability Services (Safety) Act 2001 occurs when this is required.
Timeframe (days): 90 *(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: There are policies and procedures in relation to human resource management. There is a planned and documented staff in-service education plan and staff attendance records are manintained, sighted for 2013 and 2014 in-service education plan and staff attendance records. Annual practising certificates are current for all staff who require them to practice. An orientation/induction programme is available. Staff interviews confirm orientation / induction is provided for new staff. Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals. There are areas requring improvement around staff education and adherence to the human resouce management system. ARC requirements are not fully 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: PA Low
Evidence: There are policies and procedures in relation to human resource management. Annual practising certificates are current for all staff who require them to practice.
Finding: The nurse manager's file does not evidence current performance review. Last performance review was conducted in 2012. The nurse manager states there are four registered nurses (RN) who provide weekend on call support for the facility. Reviewing two of two weekend on call RNs staff files evidences both staff files do not have employment contracts, evidence of orientation, job descriptions, peer reviews and competency assessments on files. The nurse manager states all four weekend on call RNs are volunteers and have no contracts, orientation, job descriptions, competencies, performance reviews, however they do receive on call payments.
Corrective Action: Provide evidence human resources systems are adhered to.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: There is a planned and documented staff in-service education plan and staff attendance records are manintained, sighted for 2013 and 2014 in-service education plan and staff attendance records.
Finding: There is one care giver that has not completed education related to the care of the older people (ARC D17.6.c) since their employment over a year ago. The facility policy records annual training / education will be conducted in cultural safely, The Code of Rights and restraint, however this has not occurred.
Corrective Action: Provide evidence all staff who are in direct contact with residens have completed education that is related to the care of the older people within six months of appointment and the staff education plan provides the required annual education.
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: There is a documented policy in place which sets minimum staffing levels. The policy states minimum staffing levels can be increased dependent on resident acuity, confirmed at nurse manager interview. Roster for February 2014 was reviewed and evidences adherence to policy. Minimum staffing is on night shift with one care giver rostered on site and one on call staff member (nurse manager). The nurse manager (RN) works full time from Monday to Friday and on-call after hours with other registered nurses available for weekend on call support (refer to criterion 1.2.7.3). Administration support is part time. Clinical staff interviews (three care givers and one enrolled nurse) confirm staff are able to get through their work. Residents interviewed state the care they receive is appropriate to their needs. ARC 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.)*

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)
Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

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

Attainment and Risk: FA
Evidence: The previous requirement for improvement relating to resident progress notes to have i) staff designations recorded in the progress notes and the ii) the progress notes and care plans to be part of the resident files, are now fully implemented, sighted five resident files and confirmed during the enrolled nurse (EN) interview.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)
Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)
Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)
All records are legible and the name and designation of the service provider is identifiable.

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA
Evidence:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.3: 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 Moderate
Evidence: Each stage of service provision is undertaken by suitably qualified and experienced staff members however the care plans are not currently reviewed in a timely manner, three of the five resident files reviewed are not timely. The service is coordinated in a manner that promotes continuity in service delivery and a team approach through the use of progress notes, diaries, and 'weekend handover' notes regarding changes in the resident's needs for the RN to review on a Monday morning. ARC requirements are not met. Rest Home Tracer Methodology. XXXXXX *This information has been deleted as it is specific to the health care of a resident.* ARC requirements are not fully met. Post Audit Activity – the provider and DAA could not reach an agreement on this this finding.

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: PA Moderate
Evidence: The service is in the process of changing care plans over to the InteRIA system. Four of the five resident files reviewed do not have care plans that are reviewed six monthly. The resident files evidence risk assessments including skin integrity, falls, dietician and activities assessments (Refer to criterion 1.3.7.1). The resident who's care management is reviewed does not have risk assessments completed to reflect current abilities or needs and there is not pain assessment completed for this resident although the resident is receiving controlled drugs for the management of pain and there is no evidence of neurological observations having been monitored at the time of the unobserved fall (Refer to criterion 1.2.4.3).
Finding: i) Four of the five reviewed long term care plans are not current, ii) risk assessments are not current, iii) no evidence of pain assessments being completed for residents who present with pain.
Corrective Action: Long term care plans to be current (six monthly reviews), ii) risk assessments to be reviewed in order to update care plans, iii) pain assessments to be completed for residents who present with pain.
Timeframe (days): 180 *(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: 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 1.3.5: Planning (HDS(C)S.2008:1.3.5)
Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

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

Attainment and Risk: FA
Evidence: Criterion 1.3.5.3 was identified as requiring improvement around integration of residents' files and this has been found to be met following this surveillance audit. Residents' care plans ae individualised, however they are not always updated regularly (refer to criterion 1.3.3.3)

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: FA
Evidence: Consultation and liaison with family members and with other services occurs, as demonstrated in documentation and observations made of the provision of services. Five resident files sampled evidence the care plans record interventions based on the assessed needs, however four of the care plans were not current (Refer to criterion 1.3.3.3). Five residents and five family members interviewed confirm they are satisfied with the care and treatment at the facility. Communication sheets record family communications, sighted in five resident files. ARC requirements are 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: 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 1.3.7: 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: PA Low
Evidence: Five residents, five family and staff interviews confirm the activities are appropriate to the needs of the residents

The service is in the process of orientation of a new activities coordinator (AC) under the supervision of the AC that is resigning. The service implemented a new assessment form which is more comprehensive and not all residents have the new assessment completed. The activities programme includes ordinary, unplanned or spontaneous activities such as festive occasions and celebrations. Five residents' files sampled demonstrate that support is provided within the areas of leisure and recreation, health and well-being. Residents' activities records were sighted in five residents' files sampled. Five residents interviewed confirm their past activities are considered during assessment and they have choices as to the activities they participate in. Interview with the activities coordinator was conducted. The AC commenced employment with the service in 2013. The activities coordinator (AC) works 25 hours per week. The most recent resident meeting was held in January 2013.
ARC requirements are not fully met.

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

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

Attainment and Risk: PA Low

Evidence:

The service is in the process of orientation of a new activities coordinator (AC) under the supervision of the AC that is resigning. Resident activities plans are being completed. The activities programme includes ordinary unplanned or spontaneous activities such as festive occasions and celebrations. Five residents' files sampled demonstrate that support is provided within the areas of leisure and recreation, health and well-being. Resident meeting are not held regularly, as the most recent meeting was held in January 2013. The previous finding at the certification audit was met.

Finding:

The service implemented a new assessment form which is more comprehensive and not all residents have the new assessment completed and resident meeting are not occurring regularly.

Corrective Action:

All residents to have activities assessments completed and resident meeting to be held regularly.

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

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

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

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

Attainment and Risk: FA

Evidence:

Five residents' files sampled evidence that evaluations of care plans however four were not completed in a timely manner, (Refer to criterion 1.3.3.3). Care plan evaluations are conducted with input from the resident, family, care staff, the activities coordinator and GPs. Five residents interviewed confirm their participation in care plan evaluations. Time frames in relation to care planning evaluation are documented in policies and procedures. There is

recorded evidence of input from specialist or multi-disciplinary sources. Resident files evidence referral letters to specialists and other health professionals. Multidisciplinary reviews are not current (Refer to criterion 1.3.12.1).
Following implementation of incident and accident management processes it was found that where the progress is different from expected, the service do not currently consistently respond by changing the care plan (Refer to criterion 1.3.3.3).
ARC requirements are met.

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

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

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

Evidence:

The medication room in the facility is appropriate, however the door to the medicines room cannot be locked. The medicine dispensing area is free from heat, moisture and light, with medicines stored in original dispensed packs. There is a controlled drugs storage area. The controlled drug register evidences weekly checks and six monthly physical stocktakes of controlled drugs by pharmacist, sighted. The most recent six monthly stock take occurred in April 2014.

Medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). The morning medication round in the rest home was observed. All staff authorised to administer medicines have current competencies however the nurse manager's competencies are not currently signed off by another registered nurse, but by the enrolled nurse (EN). The service has one fulltime RN, an enrolled nurse, and eight care givers who administer medicines.

Ten medicine charts were sampled. Four of the ten files reviewed do not have current three monthly reviews completed by the GP however the GP visited the service on the afternoon of the day of the audit to review the resident files in order to mitigate risk for residents and the organisation. New entries and discontinued medicines recorded on the medicines charts are signed and dated by the GP. Allergies and sensitivities are recorded and all charts have photo identification.

The nurse manager confirms that there is one resident who self-administers medicines. The service monitors the resident for self-administration of the medicines however the medicines are not currently kept in locked storage where only the resident and authorised staff have access.

The previous requirements relating to i) competencies needing to be current remains open, ii) the previous requirement for improvement relating to resident's allergies and sensitivities to be recorded is fully implemented.

ARC requirements are not fully 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 Moderate

Evidence:

Ten medicine charts were sampled. Four of the ten files reviewed do not have current three monthly reviews completed by the GP however the GP visited the service on the afternoon of the day of the audit to review the resident files in order to mitigate risk for residents and the organisation. New entries and discontinued medicines recorded on the medicines charts are signed and dated by the GP. Allergies and sensitivities are recorded and all charts have photo identification.

Finding:

Four of the ten files reviewed do not have current three monthly reviews completed by the GP and the door to the medicines room cannot be locked.

Corrective Action: All resident who are well deemed well enough in order to be assessed three monthly (rather than monthly) to have three monthly reviews completed by the general practitioner and medicines room to be securely locked.
Timeframe (days): 30 *(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 Low
Evidence: The morning medication round in the rest home was observed. All staff authorised to administer medicines have current competencies however the registered nurse' (RN) competencies are not currently signed off by another registered nurse. The service has one RN, an enrolled nurse, and eight care givers who administer medicines. Competency testing does not currently include a written questionnaire for staff members to complete. Staff members only complete an observation round with a checklist in order to be deemed competent.
Finding: The RN's competencies are not currently signed off by another RN and competency testing does not currently include a written questionnaire for staff members to complete. Staff members only complete an observation round with a checklist in order to be deemed competent.
Corrective Action: All competencies to be signed off by a registered nurse and staff members to complete written evidence of being competent to administer medicines as well as being observed during the practice of medicines management.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: PA Moderate
Evidence: The nurse manager confirms that there is one resident who self-administers medicines. The service monitors the resident for self-administration of the medicines. The resident is keeping the medicines hidden in the cupboard however the medicines are not currently kept in locked storage where only the resident and authorised staff have access.
Finding: The medicines are not securely stored.

Corrective Action: Medicines used during self-administration of medicines to be kept in secure locked storage.
Timeframe (days): 30 *(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): *(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: FA
Evidence: The nutritional assessment of residents forms part of the initial nursing assessment and with a dietary risk assessment completed by the RN which include the resident's preferences and needs relating to food and food services, sighted five assessments. Food services policies and procedures are appropriate to the service setting with winter and summer menus and four weekly menu rotation. The menu was last reviewed by a dietician in 2013, sighted. There are documented protocols for management of residents with weight-loss or gain, including referral to a dietician when required, sighted dietician input into review of residents with weight-loss. Kitchen staff are informed if resident's dietary requirements change, confirmed during interview with cook. Copies of dietary profiles were evidenced in the kitchen. Snacks are available for residents when the kitchen is closed, confirmed during interviews with care givers and the enrolled nurse (EN). Residents are offered fluids throughout the day. Residents' files sampled demonstrate monthly monitoring of resident's weight. Food temperatures are monitored and recorded, sighted. Five residents and five family members confirm during interviews, they are very satisfied with the meal service, the nutritional value of the food, the variety of food, temperature and presentation of food. Interview with the cook confirms that the service had enough food to feed the residents for at least three days in an emergency. Food stores evidence expiry dates are within the required timeframes and all food is appropriately identified. The cook monitors fridge and freezer temperatures daily.

ARC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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):	*(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 nurse manager advises there have not been any alterations to the building since the last certification audit. A Building Warrant of Fitness is displayed at the main entrance and expires on 18 July 2014.

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: The service has one resident utilising restraint and no residents using enablers. There are systems in place to ensure the use of restraint is actively minimized. Staff interviews and staff records evidence education and training relating to restraint minimisation and safe practice (RMSP). The service has a risk and quality management system of which restraint forms part of. The service's definitions of restraint and enabler are congruent with the definition in NZS 8134.0. The restraint register is current. ARC requirements are met.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

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

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

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

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

Attainment and Risk: FA
Evidence: The service completes monthly surveillance of the infections according to the number of urinary infections, chest infections, wound and eye infections as well as methcillin-resistant staphylococcus aureas (MRSA) sighted the infection log entries for all of 2013 and 2014. Specimens are sent for laboratory testing in order to establish sensitivities for prescribing of antibiotics. The infection control policy is reviewed bi-annually, last reviewed in 2013, and sighted. Surveillance data is communicated to staff member at the monthly staff meetings and the Trust Board. Data is expressed in graphs and pie charts.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA
Evidence:
Finding:

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