

Kaylex Care (Waipukarau) Limited

Current Status: 8 July 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

Mt Herbert House is one of three privately owned facilities which trade under the name of Kaylex Care Limited. The facility has 38 beds. On the day of audit it is fully occupied with 25 rest home and 13 hospital level care residents.

The day to day operation of the facility is undertaken by a facility manager who is a registered nurse. She is supported by a clinical nurse manager and staff from Kaylex Care head office as required.

The two areas identified for improvement in the previous audit are now fully attained. Two new areas identified requiring improvement relate to pain management processes and medication management.

Audit Summary as at 8 July 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

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

Consumer Rights as at 8 July 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 8 July 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 8 July 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 8 July 2014

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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 8 July 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.2)

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:	Kaylex Care (Waipukarau) Limited		
Certificate name:	Kaylex Care (Waipukarau) Limited		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Mt Herbert House		
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 8 July 2014	End date: 8 July 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:			38

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	6.5	Hours off site	4
Other Auditors	XXXXXXXX	Total hours on site	6.5	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	13	Total audit hours off site	12	Total audit hours	25
Number of residents interviewed	6	Number of staff interviewed	7	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	42	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group 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)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Friday, 18 July 2014

Executive Summary of Audit

General Overview

Mt Herbert House is one of three privately owned facilities which trade under the name of Kaylex Care Limited. The facility has 38 beds. On the day of audit it is fully occupied with 25 rest home and 13 hospital level care residents which includes one respite care resident.

The day to day operation of the facility is undertaken by a facility manager who is a registered nurse. She is supported by a clinical nurse manager and staff from Kaylex Care head office as required.

The two areas identified for improvement in the previous audit are now fully attained. Two new areas identified requiring improvement relate to pain management processes and medication management.

The requirements of the provider's agreement with the district health boards are met.

Outcome 1.1: Consumer Rights

The service can demonstrate that they provide effective methods of communication with residents and family/whanau members. This is supported by interviews undertaken and the documented annual resident satisfaction survey results.

The organisation respects and supports the right of the resident to make a complaint. Complaints management is undertaken to meet policy requirements. There is an up to date complaints register sighted. The service has one open Health and Disability Commissioner complaint which was notified in November 2012.

Outcome 1.2: Organisational Management

At governance level there are processes in place to ensure services are planned, co-ordinated and appropriate to the needs of residents. This process is overseen by the facility manager who reports directly to the owners, one of whom is the general manager. This includes key components of service delivery which are reported monthly.

The service has a well-established quality and risk management systems which is understood and implemented by staff. Quality data results, including any corrective actions that are required, are shared with staff and management. Corrective action planning is used to improve service delivery where appropriate.

Adverse events are documented and identify that family/whanau are notified as appropriate. Resident and family/whanau interviews confirm they are kept informed of any adverse events and that they are happy with the level of care and services provided.

Human resources management processes meet legislative requirements. Staff interviewed confirm they are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education both onsite and offsite.

The service implements staffing levels and skill mixes that meet contractual requirements. This was an area identified for improvement in the previous audit and is now fully attained.

Outcome 1.3: Continuum of Service Delivery

Mt Herbert House provides timely, planned, coordinated and appropriate services to its residents. At the time of admission, a short term care plan is developed for each resident, with long-term care plans developed shortly after. There is evidence of resident/family input into care planning and evaluation of progress against identified goals, and referrals being made to specialist services when additional support is required. Pain management is identified as an area requiring improvement.

At least one registered nurse is on duty 24 hours a day and they provide support and guidance to care delivery staff. There is evidence of well-developed relationships with the local medical centre, and district health board (DHB) specialist staff, who provide regular input into service delivery planning.

Two caregivers, with considerable experience in diversional therapy, organise the comprehensive and varied activities programme available to residents, providing both one-on-one and group activities. The service has its own van for outings, but also uses mobility taxis for residents with more limited mobility.

The management of medications is generally safe and appropriate (see areas for improvement identified below). All medications are administered by registered or enrolled nurses, who undergo annual assessment of their medication competency. A previous corrective action required related to observing residents swallowing of medications has been addressed. Two new areas for improvement have been identified. Each medication must be individually charted and signed for, rather than medications being grouped together and signed. When medication prescribed on an 'as-required' basis is used on a regular basis, this should be prescribed as a regular medication.

All residents interviewed expressed their enjoyment of the meals provided to them. Meals are well presented and there is a large dining room available for residents who wish to use this. Nutrition and hydration are maintained in line with recognised guidelines, and in accordance with resident preferences. The head cook and all other kitchen staff have appropriate food safety qualifications.

Outcome 1.4: Safe and Appropriate Environment

Mt Herbert House has a current building warrant of fitness that expires on 20 July 2015. There have been no changes to the building footprint since the previous audit.

Outcome 2: Restraint Minimisation and Safe Practice

Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. Currently the service has no enablers or restraint in use.

Outcome 3: Infection Prevention and Control

There is evidence of regular and appropriate surveillance activities being undertaken in accordance with the service's infection control programme. Surveillance results are graphed, and trends are analysed and benchmarked against other facilities within the organisation. Results are also reported at the health and safety meeting, discussed at the bi-monthly staff meetings, and displayed in the staff room.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	1	1	0	0
Criteria	0	36	0	1	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	1	0	33
Criteria	0	0	0	0	0	0	0	63

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Pain management is not consistent with best practice. The available pain assessment tools are not used when clinically indicated, and care plan evaluation related to pain is not completed in a timely manner. Refer also to Criterion 1.3.12.1.	Provide evidence that pain management practices are consistent with best practice.	90
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe and timely manner that	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	complies with current legislative requirements and safe practice guidelines.				
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Group signing of medication prescription is evident in five of the fourteen medication charts reviewed. When pro ra nata (PRN) analgesia is administered regularly, the GP refuses to chart this as a regular medication.	Provide evidence that all medications management meets legislative and best practice requirements.	180

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:

Policy identifies that residents have a right to full and frank information. The principles of open disclosure are embedded into everyday practice. Management operate an open door policy and any concerns or incidents are discussed with family/whanau as appropriate. This is confirmed during interviews with six of six residents (four rest home and two hospital level) and one family/whanau member. Minutes of bi-monthly resident meetings identify that any issues or concerns raised are followed up by the FM and reported back to residents at the next meeting or sooner if required.

Staff and management confirm that they can access interpreter services as required. Resident meetings, six monthly multidisciplinary clinical reviews (which include family/whanau members), bi-monthly newsletters, and large print notices placed on resident notice boards, provide an environment conducive to effective communication.

Interviews with seven of seven staff (the cook, one RN, one activities coordinator, two caregivers, one maintenance person and one household assistant) and two of two managers (the facility manager (FM) and the clinical nurse manager (CNM)) confirm their knowledge and understanding of open communication processes. Each of the seven resident file reviews contains a family/whanau communication sheet which is used to document contact.

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:

Mt Herbert House implements organisational policy related to complaints management. Interviews with six of six residents (four rest home and two hospital level) and one family/whanau member confirms the complaints process was explained to them and they can access complaints forms at any time.

The service has a complaints register in place which identifies all complaints made and shows the follow-up actions taken are used to improve services as appropriate. Complaints are reported to the owners' monthly via the FM's reporting process.

At the time of audit there is one open complaint which is being reviewed by the Health and Disability Commissioner. All required responses to date have been met by the service. One example relates to the service adopting the Hawke's Bay DHB wound care management plan. The CNM reports this is working well. Wound management plans are sighted in the files reviewed as required.

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 organisational business plan identifies the purpose, values, direction and goals of the organisation. It was last reviewed in March 2014 and covers all aspects of service delivery with set performance objectives.

The quality improvement plan for 2014 was updated in January 2014 and is reported against at weekly 'Skype' meetings with the GM/owner and the three facility managers.

The GM/owner is a RN and she works from the head office and across all three sites as required. The FM at Mt Herbert is supported by the CNM; both hold current nursing practising certificates. The job descriptions sighted show that they have the authority and responsibility for the services on site with support from staff at head office as required. Both managers interviewed on the day of audit are skilled and experienced in aged care and ensure all services are planned and coordinated in a manner to meet residents' needs.

Both staff attend in-service and off-site education on a regular basis. For example, the FM attends the Central Hawke's Bay Rural Nurses Network every three months, holds a health and safety qualification and attends DHB workshops, ACC forums and undertakes Employers and Manufacturers Association (EMA) 'webinars' to ensure her knowledge is current.

The CNM attends the infection control support group on a monthly basis via the HBDHB and Bug Control seminars and education three monthly.

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:

Mt Herbert House can demonstrate the implementation of policies and procedures to ensure they maintain quality and risk management systems that reflect the principles of continuous quality improvement. Clear links can be seen between the quality plan and the business plan. Quality and risk systems include regular ongoing audits to identify areas where corrective actions may be required. Interviews with seven of seven staff from across all areas of service confirm they understand quality systems and implement corrective actions as required. This is supported in staff meeting minutes sighted and the results of planned audits which cover all aspects of service delivery.

Policies and procedures are aligned with current good practice and meet legislative requirements. All updates and reviews are undertaken by head office and there is a system in place to ensure obsolete documents are removed from service. Staff confirm they have access to all policies and procedures. Staff are informed of policy updates and/or changes during staff meetings and via notices placed on the staff notice board.

Key components of service delivery which include health and safety, incident and accidents, infection control, restraint, complaints management and quality improvements are linked to the quality management systems. Data is shared with staff and management. Regular monthly reporting is undertaken to the GM/owner in the form of exception reporting and corrective actions taken are identified. One example relates to the increase in recorded incidents related to one resident who is often found on their knees in prayer beside their bed. Investigation identifies that this is a normal part of the resident's daily routine and following discussion with family/whanau and staff it has been decided that staff are to offer to assist the resident to pray at the times the resident nominates.

Quality improvement data is collected, analysed and evaluated and used to identify opportunities for service improvement via corrective action planning.

Actual and potential risks related to all operations of the business are identified, documented and communicated to residents, family/whanau and staff as appropriate. The service has an up to date hazard register which identifies that hazards are evaluated, monitored and discussed at the health and safety committee meetings. This is confirmed in meeting minutes sighted. Regular health and safety audits help inform the management of new hazards. Specific hazard forms are used to document findings.

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p>

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: FA

Evidence:

The FM and CNM confirm they understand and follow policy requirements related to statutory and regulatory obligations related to essential notification reporting. This process was followed in a recent outbreak of vomiting and diarrhoea which was correctly reported. (There is no confirmation of what the outbreak was as the facility is awaiting laboratory results).

All adverse or untoward events are recorded by the service on incident and accident forms. A review of the incident forms for three months (April to June 2014) identify that all incidents are reported to family/whānau as appropriate. This is confirmed during interview with one family/whānau member.

The incident and accident forms identify if a corrective action is required. All forms are reviewed by the health and safety committee.

Meeting minutes identify that incidents and accidents and related data are discussed at staff meetings and included in the management monthly report to the GM/owner. Incident and accident data is benchmarked against the other Kaylex Care facilities.

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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Staff qualifications are validated prior to employment and on an ongoing basis. Annual practising certificates are sighted for seven RNs, two ENs, five GPs, two pharmacists, and one podiatrist.

Processes are in place at organisational and facility level to ensure the appointment of appropriate service providers to safely meet the needs of residents. This is identified in job descriptions which clearly state each roles scope of practice. A review of seven of seven staff files (two RNs-one being the CNM, one EN, the maintenance person, one cleaner, two caregivers and the housekeeper) identifies that good employment processes are fully implemented and that staff files are current and well maintained. This includes evidence of orientation and induction processes, education attended, and annual appraisals being up to date.

Interviews with seven of seven staff from across the service confirm the orientation process ensures services can be delivered in a manner to meet all residents' needs.

The in-service education calendar and training content sighted identifies that staff are able to offer safe and effective care to residents. The service has worked very hard to maintain RN levels. They have worked with HBDHB so that Mt Herbert is part of the new RN graduate programme for 'new entrance to practice (NETP). The service has been the recipient of three new RNs over a two year period. The RNs and one EN are registered with the HBDHB's professional development recognition programme (PDRP) to ensure they maintain an up to date portfolio which is reflective of their knowledge and skills level to meet nursing council requirements.

All staff who do not require a practising certificate are expected and supported to complete the Certificate in Health, Disability and Aged Support (Core Competencies) level 3 via the Eastern Institute of Technology. This is a recognised qualification in the aged care arena. The content of the programme covers a wide range of topics including manual handling, safe and secure environment, advocacy and support, first aid, code of rights, challenging behaviours, culturally safe principles, personal care needs in aged care and the role of support workers.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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:

Mt Herbert House implement organisational policy related to ensuring staff skill mix meets residents' needs in a safe effective manner.

A review of the rosters identifies that staffing numbers and skill mix is maintained at a constant level and that staff are replaced for sick leave and annual leave. All shifts are covered by a RN. This was an area identified for improvement in the previous audit and is now fully attained. Staff hold current first aid qualifications which are monitored by the FM to ensure they are kept valid.

Staff report during interview that they have time to complete required tasks within rostered hours.

Interviews with six of six residents (four rest home and two hospital) and one family/whanau member confirm they are happy with standard of service provided.

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: FA

Evidence:

Mt Herbert House uses a range of information to help guide staff in the initial resident assessment and care plan development, completed by a RN within 24 hours of admission (sighted in seven of seven patient records – three hospital, four rest home), and long term care plans. All 36 permanent residents have been assessed using interRAI, and there is evidence of ongoing, regular and timely reassessments using this system in five of five patient records. The interRAI assessment is used as the basis for developing each resident's individual care plan, with the focus of the plan directly related to identified needs or potential problems. Four of four residents confirm their involvement in the assessment, care planning and evaluation processes. All new residents are reviewed by the General Practitioner within 48 hours of admission and then reviewed three-monthly, or earlier if their needs changed (as sighted in seven of seven residents' records).

Service delivery is coordinated across Mt Herbert House by the Facility Manager (FM) and Clinical Nurse Manager (CNM), both registered nurses. A verbal handover is completed at the start of each shift, there is a written handover sheet, and updated information on resident progress/status is recorded in the resident progress notes at least daily for rest home residents and each shift for hospital residents.

Tracer Number One

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

Tracer Number Two

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There is evidence in all seven patient records of regular, timely and ongoing assessment of needs using the interRAI system. Each resident has detailed, individualised care plan which is personalised in accordance with the interRAI assessment and evaluations (sighted in seven of seven care plans) developed by a RN. Where there are areas of particular concern such as diabetes, wound or pain management, 'stand-alone' care plans, separate from the main long term care plan are developed, and generally evaluated within a timely manner. One resident has a specific care plan related to pain management, and although the plan states an evaluation of the plan will be undertaken within one week, the next documented evaluation is six weeks later. The management of pain is identified as an area for improvement.

On interview, seven of seven residents and one family member confirm their satisfaction with the services provided to them, and one GP confirms his satisfaction with the care provided to residents. There are registered nurses on duty at all times, and they are available to support and guide care delivery staff. A comprehensive education programme is also available to all staff.

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

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

Attainment and Risk: PA Moderate

Evidence:

The assessment and management of a resident's pain is not consistent with best practice. Although the resident is receiving regular analgesia, and her medication is regularly reviewed by the GP, the care plan related to pain management is not evaluated in a timely manner, and there is no evidence of the available pain assessment tools being utilised in a timely manner to objectively evaluate the resident's experience of pain. For example, when the resident's analgesia is recently increased, no formal evaluation of the resident's pain levels is completed, meaning that there is no formal basis for evaluating the effectiveness of the increased analgesia. The resident's family also express concern that the resident's mobility is decreasing because of her pain on mobilising. Refer also to Criterion 1.3.12.1.

Finding:

Pain management is not consistent with best practice. The available pain assessment tools are not used when clinically indicated, and care plan evaluation related to pain is not completed in a timely manner. Refer also to Criterion 1.3.12.1.

Corrective Action:

Provide evidence that pain management practices are consistent with best practice.

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a well-developed and comprehensive activities programme at Mt Herbert House. The co-ordination of the activities programme is shared by two caregivers, who each have eight-nine years' experience in this role. Working for 7.5 hours each week day, the activities co-ordinators assess, plan and evaluate the activities preferences of each residents, with plans developed in a timely manner after admission, and revisited six monthly (sighted in seven of seven patient records). A daily record is also maintained of residents' participation in activities (sighted).

A range of group activities are provided (for example exercises, bowls, board and word games, quizzes, reading the paper; darts, bowls, crafts and visiting entertainers). There are regular trips outside the facility, using either the facility's van, or mobility taxis for residents who are less mobile. On the day of the audit visit, there is evidence of the recent mid-winter Christmas celebrations, which included a hangi lunch. There is ample evidence around the facility of the work of the knitting group, which also includes some family members. All residents are given a copy of the weekly activities programme and information is also recorded on a whiteboard. Five of the six residents interviewed express their satisfaction with the activities available. The sixth resident does not wish to join in group activities, her wishes are respected, and she receives regular visits from the activities coordinator.

Both activities coordinators maintain regular contact with other residential aged care services in their area, with residents visiting other facilities for activities such as Tournament Bowls. The co-ordinators also attend the monthly meetings of the Central Hawkes Bay Activities Group (meeting minutes sighted).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

With the exception of the pain management evaluation referred to in Criterion 1.3.6.1, all service delivery plans (seven sighted) are evaluated in a comprehensive and timely manner. Service delivery plans are resident-focused, and personalised to meet the identified needs of each resident. InterRAI assessments are reviewed six monthly (sighted). There is evidence of frequent evaluations of wounds (sighted in two residents' records), and the updating of care plans in response to changes in residents' needs. Separate care plans are developed for areas such as pain or diabetes management, with the next evaluation date recorded in the plan. When progress is different from expected, such as with wound care, there is evidence sighted (two resident's records) of plans being reviewed and updated.

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.

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

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

Attainment and Risk: PA Low

Evidence:

Appropriate medicine management processes are in place at Mt Herbert House to ensure that residents receive medicines in a safe and timely manner consistent with legislative and safe practice requirements.

All medications are administered by either a registered or enrolled nurse, all of whom have current medication competency (training records sighted). Regular medications are dispensed using the robotics system, and delivered to the facility fortnightly. The CNM and RN reports these are checked on arrival by a RN, but these checks are not documented. A medication round is observed, and the previous corrective action request related to observing residents swallowing medications has been addressed. Medications are checked against the medication chart prior to administration, a photograph of the resident on their medication chart assists staff to correctly identify residents, and they are also identified verbally prior to medication administered (observed during a medication round). Records of medication administration are complete, and a signature log of all health professionals involved in the medication process is maintained (sighted). There are currently no residents who are self-medicating (confirmed by the CNM).

All medications in the medication trolley and the stock cupboards are within their current use date, and a process is in place to ensure that all eye drops and creams currently in use are replaced monthly. The date of first use of all medications outside of the robotics system is recorded on the container (sighted). A weekly count of all controlled medications is undertaken (record sighted), and a letter is sighted detailing the date of the next six monthly controlled drug review by the pharmacist. All surplus and expired medication is returned to the pharmacy. The temperature of the medication fridge is monitored daily (records sighted).

Fourteen medication charts were reviewed (6 hospital, 8 rest home) and all included the resident's Bradma label, photograph, and their allergy status. In four of the medication charts medications have been group signed, rather than individually signed by the prescriber, and this is identified as an area for improvement. In two resident medication charts there is evidence of pro ra nata (PRN) analgesia being given on a frequent, regular basis, while a second resident has received 27 doses of another controlled drug in the period since 25 June. The CNM reports that the GP concerned has declined to re-chart these as regular, rather than prn medications, and this is identified as an area of concern.

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

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

Attainment and Risk: PA Low

Evidence:

Fourteen medication charts were reviewed (6 hospital, 8 rest home) and all included the resident's Bradma label, photograph, and their allergy status. In four of the medication charts medications have been group signed, rather than individually signed by the prescriber, and this is identified as an area for improvement. In two residents' medication charts there is evidence of pro ra nata (prn) analgesia being given on a frequent, regular basis, while a second resident has received 27 doses of another controlled drug in the period since 25 June. The CNM reports that the GP concerned has declined to re-chart these as regular, rather than prn medications, and this is identified as an area of concern.

Finding:

Group signing of medication prescription is evident in five of the fourteen medication charts reviewed.
When pro ra nata (PRN) analgesia is administered regularly, the GP refuses to chart this as a regular medication.

Corrective Action:

Provide evidence that all medications management meets legislative and best practice requirements.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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:

An experienced head cook, who has been in the position for five years, oversees meal provision at Mt Herbert House. All kitchen staff have completed food handling qualifications.

A dietary profile is completed for each new resident at the time of admission, which includes their food likes and dislikes. A list of foods disliked by individual residents is sighted in the kitchen. When there are special dietary requirements, such as diabetic diets, the cook reports this is discussed with the registered nurses. The Speech Language Therapist may also be involved when there are swallowing difficulties. A four-week menu cycle is in place, with winter and summer menus. The menu was last reviewed by a registered dietitian in November 2011. The food service caters for a range of nutritional needs, such as diabetic diets, soft and pureed diets. A range of feeding equipment, such as lip plates, feeding cups and specialised cutlery is available (sighted).

A well-lit dining room is available for residents, although residents have the choice about whether to dine there or in their rooms. Residents who require assistance with feeding are observed to be fed in a calm, unhurried, one-on-one manner in one of the smaller lounges. All six residents on interview confirm their satisfaction with food services, with several citing the food as one of the features they appreciate most about the facility. Several residents commented on their enjoyment of the hangi that was part of the recent mid-winter Christmas celebrations.

Fridge, freezer and chiller temperatures are monitored daily (records sighted). A detailed cleaning schedule is in place, and the head cook reports the cleaning is undertaken by the night staff, although this is not documented. On visual inspection, the kitchen is maintained in a safe, hygienic and tidy manner. The dishwasher was last serviced on 9 May 2014.

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:

Mt Herbert House has a current building warrant of fitness that expires on 20 July 2015. There have been no changes to the building footprint since the previous audit.

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:

Organisational restraint minimisation policy identifies the use of enablers is voluntary and that the least restrictive option is used to meet the needs of the resident. The service has no enablers or restraint in use at the time of audit. The restraint register identifies that in 2014 the only restraint used was a bedside rail for a resident following surgery which was in place from 8 February to 19 March 2014 and then discontinued. All processes are clearly documented and the restraint register is up to date.

Interviews with the FM, CNM, two RNs, and two caregivers identify their knowledge and understanding of restraint use and the difference between restraint and enablers.

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:

There is evidence of regular and appropriate surveillance activities being undertaken in accordance with the service's infection control programme. Surveillance results are graphed, trends analysed, and benchmarked against other facilities within the organisation. Results are also reported at the health and safety meeting, discussed at the bi-monthly staff meetings, and displayed in the staff room.

There is evidence of regular and appropriate surveillance activities being undertaken in accordance with the service's infection control programme. Included in the surveillance process are upper and lower respiratory tract infections, skin and soft tissue infections, urinary tract infections, eye infections and gastrointestinal upsets.

Infections are recorded on a surveillance sheet, which is entered by the FM into a database on a monthly basis, results graphed and analysed for trends (sighted). Results are discussed and minuted as part of the regular health and safety meetings and discussed at the bi-monthly staff meetings (confirmed by FM and CNM). Surveillance results are displayed in the staffroom (sighted) and also reported to Head Office so that the service can be benchmarked with other organisations. Two RNs confirm on interview about the processes associated with infection surveillance, that staff are kept informed of surveillance results and trends, and appropriate actions are taken as a result of the surveillance process.

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.)*