# Te Aroha & District Health Services Charitable Trust

## Current Status: 16 June 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 surveillance audit was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Te Aroha and District Community Hospital provides residential hospital and rest home level care for up to 44 residents, with 19 residents who required hospital level care and 16 residents who required rest home level care on the day of audit.

There is a facility manager who has been in the role since October 2013 and is supported by the clinical manager. Both managers have extensive management and aged care clinical experience. Staffing is appropriate to support the needs of residents requiring hospital and rest home care.

The one improvement required at the certification audit around the storage of self administration has been completed.

Improvements are required to the following: care planning, including documentation of oversight of care planning by a competent staff member; administration of medication; timeframes for completion of service delivery; performance appraisals and documentation of resolution of issues.

## Audit Summary as at 16 June 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 |
|  | 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 16 June 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 16 June 2014

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

### Continuum of Service Delivery as at 16 June 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 16 June 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 16 June 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 16 June 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:** | Te Aroha & District Health Services Charitable Trust |
| **Certificate name:** | Te Aroha & District Health Services Charitable Trust |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Te Aroha & District Community Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 16 June 2014 | **End date:** | 17 June 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:** | 44 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 8 |
| **Technical Experts** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 36 | Total audit hours off site | 18 | Total audit hours | 54 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 10 | Number of staff interviewed | 9 | 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 | 12 | Total number of staff (headcount) | 51 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXX, 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 Monday, 23 June 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Te Aroha and District Community Hospital provide residential hospital and rest home level care for up to 44 residents with 19 residents who require hospital level care and 16 residents who require rest home level care.  There is a facility manager who had been in the role since October 2013 and is supported by the clinical manager. Both have extensive management and aged care clinical experience. Staffing is appropriate to support the needs of residents requiring hospital and rest home care. The one improvement required at the certification audit around the storage of self administration has been completed.  Improvements are required to the following: care planning including documentation of oversight of care planning by a competent staff member, administration of medication, timeframes for completion of service delivery, performance appraisals, documentation of resolution of issues. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into daily work duties and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family and complaints were investigated. Staff communicated with residents and family members following any incident. All residents and family interviewed stated that the service was excellent. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| Te Aroha and District Community Hospital had a documented quality and risk management system that supported the provision of clinical care and support. Policies were reviewed and monthly reports from the facility manager to the board allowed for monitoring of service delivery. An internal audit and risk management programme was implemented with incidents, complaints and infection control surveillance data reviewed. Staffing levels were adequate and interviews with residents and relatives demonstrated that they had adequate access to staff to support residents when needed. The facility manager was on a fixed term contract until June 2015 with the appointment made in October 2013. The clinical manager was appointed into the position in January 2014.  Improvements are required to the following: performance appraisals and documentation of resolution of issues as these arise. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| Care was provided by a range of health professionals, however an improvement is required to ensure all elements of service delivery is completed by a suitably qualified person. All residents had a care plan documented. An additional improvement is required to ensure that all care plans reflect current needs and required interventions. The residents’ day to day needs and wellbeing was well documented in progress notes and response to interventions was monitored regularly. Care plan reviews were conducted within the time frames identified, however the formal review process requires a higher level of documentation to be documented.   Activities were planned to meet the needs of the resident. Individual activity goals were documented and ensure the provision of relevant and appropriate activities were provided. Previous interests, hobbies, culture and ability was considered. Sufficient activities and outings were provided and participation in activities was voluntary.  The required medication management policies and procedures were documented and available to staff. All medications were stored securely and the previous area identified as requiring improvement regarding the safe storage of medication had been sufficiently addressed. Medications were monitored by the registered nurses and the general practitioner. Two areas of improvement to the medication system were identified. This includes the discontinuation of transcribing by the registered nurses, and returning discontinued individually prescribed medication to the pharmacy rather than using it as ward stock.   Food services were sufficient to meet the needs of all residents. Food and nutritional needs were assessed and the menu was reviewed by a dietitian. Special needs were catered for and monitored. Food preparation and storage met food safety requirements. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| There was a current building warrant of fitness in place. There was a maintenance programme in place with hazards and maintenance issues addressed as these arose. Residents had physical access to all parts of the building and grounds. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are adequately documented guidelines on minimising the use of restraints and enablers. Alternatives to restraint are in use. There were 11 restraints/enablers in use and these were used safely and dependent on the assessed need and/or at the request of the resident. All staff received sufficient training on restraint and enabler use. |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The infection control programme was clearly documented and suitable for a hospital/rest home setting. The infection surveillance program was appropriate for the facility and the level of care provided. Infection data was externally benchmarked and analysed for trends and improvement purposes. The use of antibiotics was monitored. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 10 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 6 | 2 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is limited evidence of resolution of issues documented. | Document evidence of resolution of issues when these arise. | 180 |
| 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 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Four of the seven files reviewed do not include a current annual performance appraisal. | Ensure that all staff have an annual performance appraisal as per policy. | 180 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.1 | 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. | PA Low | There is insufficient evidence that each stage of service provision is completed by a suitably qualified person in the rest home. For example a number of assessments in the rest home have no signature of the person completing them, and one file sampled had the assessments completed by a student enrolled nurse. | Provide evidence that service delivery is completed by a suitably qualified person (in the rest home). | 90 |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | There is insufficient evidence that time frames for service delivery are consistently maintained. | Provide evidence that all timeframes for service delivery are maintained as required. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Not all current needs and interventions are documented in care plans. | Provide evidence that all current needs and interventions are documented in care plans. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.2 | Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | There is insufficient evidence that care plan evaluations are documented, consumer focused or indicate the degree of achievement towards interventions and outcomes. | Fully document resident evaluations. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA 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 | Transcribing is sighted in six out of six medication records sighted in the hospital. (ii) There are two examples of individually prescribed medication being used as ward stock. | Discontinue transcribing. (ii) Discontinue using individually prescribed medication for ward stock. | 7 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Medication competency is not observed in the rest home during the audit. | Provide evidence that all staff are competent to administer medication. | 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:** |
| Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.  Residents interviewed (including seven residents using rest home services and three using hospital services) state that there is good communication with staff and comment particularly on the fact that staff are approachable and supportive.  Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 17 of 17 completed accident/incident forms and in the resident files.  Family contact is recorded in residents’ files – sighted in six of six resident files reviewed (two rest home and four hospital).  Interviews with six family members (three hospital and three rest home) confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings for their family member.  Family interviewed confirm that they are invited to attend the resident meetings. Interpreter services are available when required from the District Health Board. There are no residents currently requiring interpreting services.  The information pack is available in large print and advised that this can be read to residents. Staff have had training around open disclosure in March 2014.  The District Health Board contract requirements 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 organisation’s complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes time frames for responding to a complaint.  Complaint’s forms are available at the entrance of the rest home and hospital. There is also a ‘mail’ box and anyone can put a note in the box with follow up according to the complaints policy.  A complaints register is place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder. Two complaints lodged in 2014 were selected for review. There is documented evidence of time frames being met for responding to these complaints with documentation indicating that the complainants are happy with the outcome.  Interviews with six family members (three hospital and three rest home) and residents interviewed (including seven residents using rest home services and three using hospital services) state that they would feel comfortable complaining. All stated that they had had no need to complain.  The facility manager states that there have been no complaints with the Health and Disability Commission since the last audit or with other authorities. The District Health Board contract 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:** |
| Te Aroha and District Community Hospital is a community based residential service that enjoys close support and governance from an active board.  A previous board member is currently appointed as the facility manager following the resignation of the previous manager. The facility manager has previously undertaken consultancy work as acting facility manager with the service prior to stepping into the role in October 2013 (last day of the previous chief executive officer i.e. facility manager being 17 October 2013).  Communication between the board and the facility manager is through monthly reports which detail progress against all quadrants (financial, service delivery, staffing and customer service).  The facility manager is now on a fixed term contract until June 2015. The facility manager has extensive consultancy including management experience in aged care for five and a half years.  Te Aroha and District Community Hospital has a clear mission, values and goals and these are currently being reviewed.  The facility can provide care for up to 46 residents requiring hospital or rest home level of care with Lawrence House designated as a stand alone 15 bed rest home. During the audit there are 35 residents living at the facility including 16 residents at rest home level of care and 19 residents at hospital level of care. As part of the hospital level of care provided, the service takes residents who are identified as having continuing care needs (under the medical part of the hospital contract with three residents currently in the service) and residents who identified as having short term needs referred by the general practitioner (currently one resident in the service).  The facility manager is responsible for the overall management of the facility.  The clinical manager is a registered nurse who was appointed in January 2014 with a three week orientation by the previous clinical manager. The clinical manager has a Bachelor of Nursing degree and has 10 years’ experience in aged care facilities as a team leader.  The District Health Board contract requirements are 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:** PA Low |
| **Evidence:** |
| Te Aroha and District Community Hospital has a documented quality and risk management framework that guides service delivery including practice.  The facility manager has documented a plan to guide review and further development of the business. This is the business plan in the interim. The facility manager reports monthly to the board on progress including financial monitoring, review of staff costs, progress against the workplace plan, review of complaints, incidents, relationships and marketing of the service.  The facility manager is also responsible for managing the relationships with Office Treaty Services who own the building and land.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff with some in hard copy at the nurses stations all others documented electronically.  All staff interviewed including four of four caregivers, the two activities coordinators, the clinical manager, the facility manager, the cook and four registered nurses and the team leader for domestic and housekeeping services who takes a quality project role report they are kept informed of quality improvements. The organisation has a risk management programme in place. Health and safety policies and procedures are documented. There is evidence that any hazards and maintenance issues are identified are signed off as addressed or risks minimised or isolated. There is a hazardous substance register documented and a hazard register completed and reviewed through the meetings.  The health and safety coordinator is the facility manager with a signed job description documented.  Resident/family satisfaction surveys are completed and analysed six monthly.  Service delivery is monitored also through complaints, review of incidents and accidents and surveillance of infections. There are meetings held across the service including monthly staff and monthly service type meetings e.g. registered nurse, activities staff, domestic etc. All aspects of the quality and risk management programme are discussed through the meetings. The facility manager is starting focus groups to discuss specific quality projects with members of staff attending as per project need.  The service is part of an external benchmarking programme around infection control. There is an internal audit schedule implemented and this serves to monitor service delivery. The results are reviewed through the meetings and the team leader, facility manager and the clinical manager can discuss improvements made with corrective actions documented. An improvement is required to documentation of resolution of issues. The District Health Board contract requirements are partially 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:** PA Low |
| **Evidence:** |
| Corrective action plans are documented when issues arise e.g. from internal audits, satisfaction surveys and meeting minutes. |
| **Finding:** |
| There is limited evidence of resolution of issues documented. |
| **Corrective Action:** |
| Document evidence of resolution of issues when these arise. |
| **Timeframe (days):** 180 *(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 facility manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified apart from notification of the change in facility manager and the change in clinical manager. The facility manager has also notified the District Health Board and HealthCERT of a recent serious event that occurred for a contractor with Work Safe investigating the event. There have been no outbreaks since the last audit.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the facility manager and clinical manager.  Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.  Seventeen incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at the monthly staff meeting.  Health and safety reports are completed by staff including accidents, incidents, hazards and near misses. A risk calculation for each event is completed that includes a probability rating and consequence. All events documented are reviewed and signed off by the clinical and facility managers.  The District Health Board contract requirements are met. |

##### **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:** PA Low |
| **Evidence:** |
| All registered nurses and the clinical manager hold current annual practising certificates. Visiting practitioner’s practising certificates include the general practitioner, dietician, podiatrist and pharmacist.  Seven of seven staff files randomly selected for audit includes appointment documentation on file including signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process that is continuing to be updated to ensure that all staff have a current performance appraisal. There are three files with a current performance appraisal in place. An improvement is required to completion of performance appraisals annually. The facility manager is working through completion of these.  First aid certificates are held in staff file along with other training records. All registered nurses and enrolled nurse have completed CPR at Christmas time and there is always a caregiver rostered on duty in the rest home with a current first aid certificate.  Police checks are completed – sighted in all employee files reviewed. Volunteers also have a police check and signed agreement.  All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and caregivers who administer medicines to residents (sighted).  The four caregivers state that they value the training. Education and training hours exceed eight hours a year. There are attendance records and training records maintained by the clinical manager.  The cooks have a record of completing food service and chemical safety training.  The District Health Board contract requirements are partially met. |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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:** |
| Staff are expected to complete annual performance appraisals which serve to identify training needs. The facility manager is working to complete these.  There is a training schedule and records of training documented. |
| **Finding:** |
| Four of the seven files reviewed do not include a current annual performance appraisal. |
| **Corrective Action:** |
| Ensure that all staff have an annual performance appraisal as per policy. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The staffing guidelines developed by an independent consultant is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.  There are a total of 51 staff including the facility manager, two activities coordinators covering both rest home and hospital and five days a week, two cooks, nine domestic/housekeeping staff, one enrolled nurse, four registered nurses, 21 caregivers, clinical manager, two administration and a team leader. Caregivers complete personal washing and the other linen is outsourced to Spotless. Maintenance is outsourced to the Council. There are other casual staff who relieve in all positions. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.  The rosters for an occupancy of 35 residents are as follows: There is one registered nurse on each shift. On a Monday there is a second registered nurse in the morning. An enrolled nurse is rostered on five days a week Monday to Friday and they are involved in developing the rosters, doctor’s rounds and wound management with oversight form the registered nurse. Registered nurses provide support for both the rest home and hospital.  In the rest home (15 residents) there is one caregiver on a full shift and one caregiver for two hours in the morning; one caregiver full and one short shift in the afternoon and one caregiver overnight.  Hospital: In the morning, there are three caregivers (full shifts) plus one caregiver for an hour for support to help residents to shower, two caregivers in the afternoon and one overnight.  The call bell at the rest home (stand-alone building) is connected to the hospital building and staff can be alerted and do attend any call outs as soon as they arise as confirmed by the four caregivers interviewed.  The clinical manager works 40 hours a week and is on call with anther registered nurse on call if the clinical manager is not available.  The service does not use bureau staff and any leave is covered by staff in the facility or the clinical manager. If the clinical manager is on leave, the position is covered by another registered nurse who completes the registered nurse roster.  Residents and families interviewed confirm staffing is adequate to meet the residents’ needs. The District Health Board contract requirements are met. |

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policies and procedures require each stage of service provision to be completed by a suitably qualified person. This includes the requirement for a registered nurse to complete all assessments, care plans and care plan reviews. Six resident files are sampled. This includes the records of four residents receiving hospital level care and two residents receiving rest home level care. Full implementation of the registered nurse completing the required assessments could not be verified within the sample and an improvement is required.   Interventions and support with activities of daily living are implemented with the help of trained health care givers and allied health providers. Care givers interviewed are well versed in their required tasks and keep records of all daily interventions.  Timeframes for service delivery are defined. This includes the time frame for completing assessments of admission, initial care plans and long term care plans. All records sighted have had the long term care plan completed within the required timeframe, however time frames for documenting/completing assessments and initial care plans could not be confirmed within the files sample and an improvement is required.  The residents’ condition is reviewed monthly and this is fully documented in progress notes. There is evidence that care plans are reviewed every six months as required and all residents are reviewed every three months by their general practitioner, unless required more frequently. Short term care plans are developed in the event additional cares are required, and these are consistently sighted within the sample.  Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement and daily handovers ensure day to day continuity. A handover is observed and confirms that adequate and appropriate information is shared between nurses and staff. Registered nurses also attend regular meetings which include a large clinical component and ensure all nurses are kept aware of the residents’ current condition. Clinical reports are also communicated to the board every month. These include, for example, the number of wounds, infections, falls and use of restraints.  The district health board requirements are partially met. Residents are assessed by their general practitioner on entry and this is evident in the sample and care plans include the required domains. The provider has commenced the use of the InterRAI assessment tools.  Tracer methodology for rest home resident. *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology for the hospital resident. *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:** PA Low |
| **Evidence:** |
| A number of assessments sighted in the rest home have not been signed by the person completing them; therefore the designation of the assessor could not be confirmed. One resident file in the rest home had the full number of assessments completed; however these had been signed by a student enrolled nurse and were not counter signed by a registered nurse. |
| **Finding:** |
| There is insufficient evidence that each stage of service provision is completed by a suitably qualified person in the rest home. For example a number of assessments in the rest home have no signature of the person completing them, and one file sampled had the assessments completed by a student enrolled nurse. |
| **Corrective Action:** |
| Provide evidence that service delivery is completed by a suitably qualified person (in the rest home). |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The time frames for documenting/completing/updating assessments and initial care plans could not be consistently confirmed. |
| **Finding:** |
| There is insufficient evidence that time frames for service delivery are consistently maintained. |
| **Corrective Action:** |
| Provide evidence that all timeframes for service delivery are maintained as required. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

|  |
| --- |
| **Attainment and Risk:** 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 Low |
| **Evidence:** |
| Interventions are documented for each nursing objective/goal within the care plan and there is evidence in progress notes that the required interventions are being provided, however not all the current interventions have been recorded in the current care plan and an improvement is required.   The provider uses a number of short term care plans when required. Short term plans and interventions sighted within the sample include pain, impaired skin integrity, dehydration, wounds, infections, tube management, weight monitoring and behaviour. Wound care plans include the required assessment and monitoring interventions, as does the care plan for a resident with an infection. In addition, regular interventions such as nursing observations and care giver tasks are documented. These include bowel charts, temperature/pulse and blood pressure charts and activities of daily living charts. There is a system in place to ensure these interventions are monitored by the registered nurses and this is confirmed in records sampled.  The District Health Board requirements are partially met. |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Care plans include the required interventions. Six care plans are sampled and not all interventions have been recorded in the current care plan or related records. Examples included with the resident sample include: the administration of regular medication for one resident who has been prescribed pain medication, no cross reference to a behaviour chart within a care plan, the completion of wound care plans, no mention of a chronic wound in another resident’s care plan, no mention of the interventions required to manage an indwelling catheter in another resident’s care plan and no mention of the required interventions to manage the skin integrity of another resident who has skin cancer. A low risk is allocated as the required interventions are evident in the progress notes sampled. |
| **Finding:** |
| Not all current needs and interventions are documented in care plans. |
| **Corrective Action:** |
| Provide evidence that all current needs and interventions are documented in care plans. |
| **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:** |
| An activity programme is provided in both the rest home and hospital. These are developed and coordinated by the designated activities coordinator (in the rest home) and the diversional therapist (in the hospital). The activities programmes are sighted and both provide a sufficient range of planned activities to develop and maintain strengths and interests. Outings are provided for those able to partake, this includes residents in the hospital.  Each resident has a social/activities assessment completed on entry. From this an individual activities care plan and goals are developed. Records of individual attendance at activities is documented. Activities assessments and care plans are comprehensively documented.   Residents in both areas are observed partaking in activities during the audit. Activities are also supported by volunteers. Residents and family interviewed are satisfied with the activities provided and confirm participation is voluntary.   The District Health Board requirements are 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:** 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:** PA Low |
| **Evidence:** |
| Care plans are required to be formally reviewed every six months, and the existing care plan updated as required. The clinical manager has recently implemented a new system whereby the registered nurses are allocated a number of residents each, for which they are responsible for ensuring the care plans are current and updated.   Six resident records are sampled. A monthly review of progress notes is documented and care plans include a signature and date of when the care plan was last reviewed, however the multidisciplinary care plan evaluation form (which includes the achievement towards goals and response to interventions) has not been consistently utilised and an improvement is required.   Daily checklists are completed by the care givers which indicate achievement in activities of daily living. Wound and infection care plans are also evaluated as and when required. Three monthly GP reviews are also evident in resident files sampled. Residents and family members state they are involved in the care planning and review process.   The District Health Board requirements are partially met. |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is sufficient evidence that care plans and interventions are reviewed in an ongoing manner. This includes a monthly review in the progress notes. A multidisciplinary care plan evaluation form is available. This is comprehensive and includes a full review of each of the care plan domains and provides a trigger for updating assessments (if required). There is also opportunity for input from other staff, family and significant others. A copy of these forms are kept in the resident’s room, and once complete, are required to be filed in the resident records. Care plans are then signed to provide evidence that a review has been completed and this is evident in files sampled, however the multidisciplinary evaluation forms are sighted in one out of six resident records sampled. |
| **Finding:** |
| There is insufficient evidence that care plan evaluations are documented, consumer focused or indicate the degree of achievement towards interventions and outcomes. |
| **Corrective Action:** |
| Fully document resident evaluations. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

|  |
| --- |
| **Attainment and Risk:** 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:** |
| There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice guidelines.   A robotics medication system is implemented. All medicines are prescribed by the general practitioner, however the medication orders are currently being transcribed by the registered nurses and an improvement is required. Standing orders are sighted and meet the requirements of the 2012 guidelines. Standing orders have been reviewed recently by the visiting general practitioner and include problem, criteria, interventions, timeframes and maximum dose.  Medication reconciliation is completed when medication enters the facility. All medications from the pharmacy are checked, as is medication brought in by residents on the first day of admission.  Twelve medication charts are sampled (eight in the hospital area and four in the rest home area). Medication records include suitable identification and allergies are recorded. Three monthly general practitioner reviews are also evident in all records sampled.  Medications are safely stored in medication trolley in both the rest home and hospital .Stocked medications are safely stored in the hospital dispensary. Routine checks are conducted for expiry dates and medication fridge temperatures are monitored. Controlled drugs are kept securely and checked regularly as required. The pharmacy has recently conducted the required six monthly stock take. Non packaged medications are labelled and dated (if required) when opened. Two examples of individually prescribed medication being used as ward stock are sighted and an improvement is required.  Medications are administered by registered nurse and senior care givers. Competencies for medication management are monitored and medication competency records are sighted. A lunch time medication round is observed and confirms administration is safely maintained in the hospital setting, however full competency is not observed in the rest home and an improvement is required.   There is a process for assessing the competency of residents who self-medicate their own medications. Two assessment records of residents who self-medicate are sighted. These have been signed by the registered nurses, and although they have not been co-signed by the resident’s general practitioner (as required on the form) there is no requirement to do so in the self-medication policy. The previous improvement identified regarding safe storage of medication for residents who self-administer has been adequately addressed.  The District Health Board requirements are partially 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:** |
| Registered nurses are transcribing medications. This includes writing the required drug, dose and frequency onto both medication charts and administration records. On discussion with the registered nurses, this practice occurs to ensure medications are provided in a timely manner. This practice is only occurring in the hospital. All medication charts and administration records in the rest home have been generated from the pharmacy. This high risk non-compliance is addressed the day following the audit, with immediate correspondence to the general practitioners. Email correspondence sighted confirms that the District Health Board is satisfied with the immediate corrective actions and advised the auditor to lower the risk rating to moderate.  It is observed that two individually prescribed medications have had the labels defaced and are being used a ward stock in the hospital |
| **Finding:** |
| Transcribing is sighted in six out of six medication records sighted in the hospital. (ii) There are two examples of individually prescribed medication being used as ward stock. |
| **Corrective Action:** |
| Discontinue transcribing. (ii) Discontinue using individually prescribed medication for ward stock. |
| **Timeframe (days):** 7 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| All care givers interviewed are aware of their requirements regarding medication management and administration. A medication competency process is implemented and competency records are sighted in all staff files sampled. A lunch time medication round is observed in both the rest home and hospital area. Medication trolleys are taken to the lunch room and the residents’ are provided with sufficient fluid. The trolley is kept within sight, however the staff member in the rest home area is observed signing the administration chart prior to administering the medication and moving on to the next resident without observing that the medication has been taken. |
| **Finding:** |
| Medication competency is not observed in the rest home during the audit. |
| **Corrective Action:** |
| Provide evidence that all staff are competent to administer medication. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.5 (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:** |
| Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. There is a 15 day menu (summer and winter) and the menu is currently being reviewed by a registered dietitian to confirm it is appropriate for the nutritional needs of the older person. Deviations from the menu, occurring as a result of the availability of fresh produce, or in response to individual likes and dislikes, are recorded.   Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. For example there is currently five residents requiring a diabetic menu and protein shakes and moulied meals are provided.   Weight management is included in the clinical statistics reported monthly to the board. The April and March board reports are sighted and confirm 100% of the required documentation is completed and no weight loss recorded.   Residents are weighed monthly and confirm nutritional needs are being sufficiently addressed. Where required, additional nutritional support is documented and appropriate interventions implemented. This includes referrals to a dietitian as required. The GP reviews weight charts during medical review.   Residents interviewed are satisfied with the food. The meal service is observed on both days of the audit. Meals appear well presented and sufficient in quantity.   The cook is interviewed and has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained and this includes temperature monitoring. A kitchen hazard list is sighted in the kitchen, as is a first aid kit and material safety data sheets. The provider also provides up to 20 meals on wheels per day for people in the community.  The District Health Board 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:** |
| A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 8 September 2014). There have been no building modifications since the last audit.  Maintenance issues are addressed as these arise. The Office Treaty Services are responsible for maintaining the exterior of the building and any painting of the exterior of the building will not be completed until iwi settlements have occurred.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit. The areas are suitable for residents with mobility aids.  The facility manager accesses funding to refurbish rooms as residents leave the facility. There are rails and ramps in all areas that allow access for residents both internally and externally. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

# 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 provider actively works to reduce the use of restraint. Low beds and landing strips are provided for residents who are at risk of falling out of bed. The current restraint register is sighted and states there are currently 11 restraints/enablers in use. This includes bed rails and lap belts which are either identified as a restraint and/or enabler dependent on the voluntary use.  All staff receive education on the use of restraints, enablers and the management of behaviours of concern. The definition of restraint and enablers is congruent with the relevant standard. |

##### **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 infection surveillance programme is appropriate for the facility and the level of care provided. The infection control coordinator is interviewed. The monthly resident care plan review includes review of any infections and the outcome of treatment.   Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Staff interviewed report they are made aware of any infections of individual residents. Infection data is also included in registered nurse meetings and reported in board reports. Doctors are informed if their resident has an infection and resident infection summary forms are sighted in resident files.  Surveillance data is separated between rest home and hospital infections. The register includes site, antibiotic, organism, and outcome. Use of antibiotics is monitored and infection rates are benchmarked against other similar services (measured per 1000 bed days) for quality improvement purposes, for example training purposes. Surveillance data sighted shows that the infection rate is higher in the hospital than in the rest home. For example 9.9 per 1000 bed days in the hospital and 4.4 in the rest home.  The District Health Board requirement is met. |

##### **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.)* |