# Karaka Court Limited - Woodlands of Palmerston North

## 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

Woodlands Palmerston North is owned by Karaka Court Limited who operate two homes in the Manawatu. Woodlands provides care for up to 23 rest home and 12 dementia residents. On the day of audit there are 22 rest home residents, plus three boarders, and 11 residents in the dementia unit.

Woodlands is managed by an experienced manager, who is also supported by a clinical leader with access to additional clinical support from the Fielding facility. There are well developed systems to provide quality care for residents. There is an orientation and training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The findings from the certification audit around incident reporting and documentation following a clinical incident have been met. This audit identified two areas of improvement around care planning and menu review.

## 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. |  | Standards applicable to this service fully attained. |

### 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 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 4.2)

## **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:** | Karaka Court Limited |
| **Certificate name:** | Karaka Court Limited - Woodlands of Palmerston North |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Woodlands Of Palmerston North |
| **Services audited:** | Rest home care including dementia care |
| **Dates of audit:** | **Start date:** | 16 June 2014 | **End date:** | 16 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:** | 36 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11 | Total audit hours | 27 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 5 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 28 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Wednesday, 23 July 2014

## **Executive Summary of Audit**

**General Overview**

Woodlands Palmerston North is owned by Karaka Court Limited who operate two homes in the Manawatu. Woodlands provides care for up to 23 rest home and 12 dementia residents. On the day of audit there are 22 rest home residents, plus three boarders, and 11 residents in the dementia unit. Woodlands is managed by an experienced manager, who is also supported by a clinical leader with access to additional clinical support from the Fielding facility. There are well developed systems to provide quality care for residents. There is an orientation and training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The findings from the certification audit around incident reporting and documentation following a clinical incident have been met. This audit identified two areas of improvement around care planning and menu review.

**Outcome 1.1: Consumer Rights**

There is an open disclosure policy. Interviews with residents and relatives confirm family are kept informed of their family members current health status including any adverse events. A complaints process is implemented.

**Outcome 1.2: Organisational Management**

The service continues to implement a quality and risk management framework that includes management of incidents, complaints, infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. There is an appropriately experienced manager who provides guidance for the service and is supported by a clinical leader and experienced care staff. The clinical leader provides clinical oversight during weekdays and there is registered support available afterhours. There is an implemented in-service training schedule. The service has sufficient staff allocated to enable the delivery of care. The previous required improvement around incident reporting has now been met.

**Outcome 1.3: Continuum of Service Delivery**

The sample of resident files reviewed demonstrates implemented systems to assess, plan and evaluate care needs of the residents. The resident’s needs, interventions and goals have been identified and these are reviewed on a regular basis with the resident and/or family input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. There is an improvement required around aspects of care planning documentation. Medical policies and procedures are in place to guide practice. Education and medicines competencies are completed by all staff responsible for administration of medicines. The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis. All food is cooked on site. Residents nutritional needs are identified, documented and choices are available. The menu has not been reviewed by a dietitian since 2011 and this is a required improvement. The required improvement from the certification audit relating to documentation following a clinical event has been met.

**Outcome 1.4: Safe and Appropriate Environment**

The service displays a current building warrant of fitness which expires on 30 June 2014.

**Outcome 2: Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are documents to support the policy. Currently there are no residents with restraint or enablers. There is a restraint meeting six monthly. Staff are trained in restraint minimisation, challenging behaviour and de-escalation

**Outcome 3: Infection Prevention and Control**

There is an established and implemented infection control programme that is linked to the quality system with monthly reporting of surveillance data being undertaken.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 0 | 0 | 0 |

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

## **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 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 | One resident with weight loss does not have documented interventions updated in the care plan. | Ensure that interventions are updated in the care plan to reflect the resident current health needs. | 90 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The menu has not been reviewed by a dietitian since February 2011 | Ensure that the menu is reviewed by a dietitian. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Nine of nine incident forms reviewed (five rest home residents and four dementia unit) identify family were notified following a resident incident. Interview with two caregivers (one rest home and one dementia unit) and the clinical leader inform family are kept informed.
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry
D16.1b.ii the residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b relatives (one rest home and three dementia) stated that they are informed when their family members health status changes.
D11.3 The information pack is available in large print and this can be read to residents.

##### **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:**

There is a complaints policy to guide practice. The manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) register that records activity in an on-going fashion. Complaints are discussed at the monthly staff meeting. The last recorded complaint is March 2012 and is seen to have been investigated with the outcome provided to the complainant. Discussion with six residents and four relatives (one rest home and three dementia) confirm they are aware of how to make a complaint. There have been a number of compliments that have been received across the 2014 period.
D13.3h. a complaints procedure is provided to residents within the information pack at entry.

##### **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:**

Woodlands Palmerston North provides care for up to 38 residents across two service levels (rest home and dementia). On the day of audit there were 22 (of 23) rest home residents and 11 (of 12) residents in the dementia unit. There are also three boarders.

There is a 2014-2015 Business Plan that covers both the Palmerston North and Fielding facilities and outlines objectives for the period. Woodlands Palmerston North identifies goals for the 2014 year that include upgrading the bathroom facilities. There is an established and implemented quality programme that includes discussion about clinical indicators (e.g. incident trends, infection rates), at the monthly staff meeting. The full time manager (non-clinical) reports through to the director (owner) monthly and is supported by a clinical manager (clinical leader (RN)) who works 35 hours/week.

The service is managed by an experienced manager who has been in post for five years. The clinical manager (RN) is in a maternity leave position until August (2014) and has come from the Woodlands Fielding facility. The clinical manager was New Zealand registered in December 2012. There is a team of experienced care staff, a number of who are overseas clinical leader (RN)s working towards gaining New Zealand registration through UCOL.

D17.3di, the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** FA

**Evidence:**

Woodlands Palmerston North is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed in line with best practice, and the manuals have been reviewed this year (2014). The content of policy and procedures are detailed to allow effective implementation by staff.
Quality matters are taken to the monthly staff meetings that all staff are invited to attend. Meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings (monthly).

Woodlands Palmerston North is implementing an internal audit programme that includes aspects of clinical care – such as medication audit. Issues arising from internal audits are reported on the Corrective Action Form and are seen to have been closed out.

D19.3:There is a H&S and risk management programme in place including policies to guide practice. The clinical manager is the health and safety coordinator for the facility who monitors staff accidents and incidents. The hazard register has been reviewed this year (2014).
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the staff meeting. Incident forms are completed by staff, the resident is reviewed by the clinical leader (RN) at the time of event if she is on site, and is notified by care givers of incidents afterhours. Family are notified by the clinical manager. Nine incident forms were reviewed – five from the rest home and four from the dementia unit. All had been completed appropriately. Three files were reviewed (two rest home, one dementia) and all reported incidents had an accompanying incident form. The finding from the certification audit has been closed out.
D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.
Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

##### **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:**

There are human resources policies to support recruitment practices. The clinical managers practising certificate is on file. Six staff files were reviewed (clinical manager – also the infection control and restraint coordinator, diversional therapist, cook, three caregivers – two who work in the dementia unit) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (two caregivers, clinical manager) were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is an annual education plan that includes all required sessions as part of these standards. The plan is being implemented. There are a number of care givers who are overseas clinical leader (RN)s and completing training at UCOL which provides additional and diversity of training in addition to that prescribed by these standards. Interview with two care givers confirm in-service training is being provided. Medication competencies are in completed annually for caregivers (and the clinical manager) who are administering medication.

There is a staff member with a current first aid certificate on every shift.

E4.5f: There are 15 caregivers who work in the dementia unit, all have completed 'gerontology level 7' from UCOL (sighted) and are overseas RN's who are attending UCOL working towards NZ registration. The provider reported this qualification is sufficient to meet contractual requirements for working in the dementia unit. The activities coordinator is a trained diversional therapist

##### **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:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: five caregivers in the morning (two in the dementia unit and three in the rest home), four during the afternoon (two in the dementia unit and two in the rest home) and two on night shift (one in each area). The manager work full time and the clinical manager 35 hours/week. Both are on call afterhours. The activities coordinator works 40 hours per week. The caregivers, residents and relatives interviewed inform there is sufficient staff on duty at all times.

##### **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:**

D16.2, 3, and 4: The five resident files reviewed (three from the rest home, and two from the dementia unit)) identify an initial nursing assessment and care plan was completed within 24 hours and a long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by the clinical leader (RN) and amended when current health changes (link 1.3.6.1). Four of five care plans evidence evaluations completed at least six monthly including a care plan evaluation form and a lifestyle plan revisions form with revised goals and interventions. One rest home resident has not yet been at the service for six months. Activity assessments and the activities care plans have been completed by the diversional therapist. Six rest home residents interviewed state they and/or their family were involved in planning their and at evaluation. Resident files included family contact records - completed in all resident files sampled.

D16.5e: All resident files reviewed identify the GP has seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly for rest home and dementia residents. More frequent GP review was evidenced as occurring on review of resident’s files with acute conditions.

A range of assessment tools are completed in resident files on admission and at least six monthly including (but not limited to); a) falls risk assessment, b) pressure area risk assessment, c) continence assessment d) mobility assessment e) pain assessment and f) challenging behaviour assessment. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Five files reviewed identified integration of allied health and a team approach is evident.

Resident files samples included: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer Methodology Rest Home

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

Tracer Methodology Dementia.

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 Low

**Evidence:**

Five resident files were reviewed (three rest home, two from the dementia unit). An initial nursing assessment and care plan were completed within 24 hours and a long term care plan completed within three weeks in all files reviewed. The care plans are completing and reviewed by the clinical leader (RN) and amended when current health changes in four of five files sampled (one was not due for review). One rest home resident from the dementia unit with XXXX has no documented interventions updated in the care plan to reflect the residents current health needs. This is an area requiring improvement.

Four of five care plans evidenced evaluations completed at least six monthly (including lifestyle plan) with revised goals and interventions. One rest home resident has not yet been at the service for six months. Activity assessments and the activities care plans have been completed by the diversional therapist. The care being provided is consistent with the needs of residents – verified by interview with six rest home residents, four family (one rest home, three dementia unit), clinical leader (RN) (RN) and manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrate integration. There is evidence of three monthly medical review for rest home residents and dementia residents.

Care delivery is recorded in the progress notes at very shift (evidenced in all five residents' progress notes sighted) by either the caregivers and/or RN. The RN documents in the progress notes when there is a change in the resident’s condition or health need and following resident’s incidents (sighted and interview). This was a finding from the certification audit relating to documenting care following a health event that has been addressed and this is now closed. Two caregivers (one from the rest home and one from the dementia unit) and the clinical leader (RN) inform they have sufficient equipment to provide care, including wheelchairs, sit on weighing scales, pressure mattresses, commodes, shower chairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. Staff confirm there is adequate continence and dressing supplies (sighted during audit). Six rest home residents and four family (one from the rest home and three from the dementia unit) interviewed are complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for four residents (two from the rest home and two from the dementia unit). Both residents in the rest home have documented skin tears. One resident in the dementia unit has XXXXX and also XXXXXX. One other resident in the dementia unit also has XXXXX.

The clinical leader (RN) (RN) interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service has been provided in 2013.

During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents’ rooms and ensured residents’ privacy. Residents interviewed were able to confirm that privacy and dignity was maintained.

##### **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:**

Five resident files reviewed (three from the rest home and two from the dementia unit) identified an initial nursing assessment and care plan was completed within 24 hours and the long term care plan was completed within three weeks. The care plans were reviewed by the clinical leader (RN) and amended when current health changes in four of five files sampled. Four of five care plans evidenced evaluations completed at least six monthly including a care plan evaluation form and a lifestyle plan revisions form with revised goals and interventions. One rest home resident has not yet been at the service for six months. Activity assessments and the activities care plans have been completed by the diversional therapist. The care being provided is consistent with the needs of residents, confirmed by interview with six rest home residents and four family (one form the rest home and three for the dementia unit), one clinical leader (RN) and one manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical review for rest home residents and dementia residents. Residents' care plans are completed by the clinical leader (RN). Care delivery is recorded and evaluated in the progress notes at very shift (five of five resident files). When a resident's condition alters, the clinical leader (RN) initiates a review and if required, arranges a GP visit. Two caregivers (one from the rest home and one from the dementia unit) and one clinical leader (RN) interviewed state they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, sit on weighing scales, pressure mattresses, commodes, shower chairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. The clinical leader (RN)s interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

**Finding:**

One resident with weight loss does not have documented interventions updated in the care plan.

**Corrective Action:**

Ensure that interventions are updated in the care plan to reflect the resident current health needs.

**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 diversional therapist at Woodlands who is responsible for the planning and delivery of the activities programme. The diversional therapist (DT) has been in this role for six years and completed the diversional therapy qualification four years ago. The DT works Monday-Friday 8.30am – 5pm. She interacts with other diversional therapists at meetings and is currently completing a dementia course “Walking in Their Shoes”. The DT plans separate programmes from the rest home and dementia unit. There is a monthly programme which is displayed on the notice boards and in every resident’s room and daily activities displayed on a white board. Activities are provided in the various lounges, dining areas, gardens (when weather permits) and one on one input in resident’s rooms when required. The DT plans her time between the rest home and dementia unit. The caregivers assist in delivering the programme. On the day of audit residents were observed being actively involved with a variety of activities, including sing along and an outing to the Friendship Club in the community. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events and information from this is added into the activities care plan. A daily attendance record is kept for each resident and progress notes completed monthly. Review and evaluation of the care plan is completed six monthly. The resident/family/EPOA as appropriate is involved in the development of the activity plan.

The programme includes residents being involved within the community including weekly visits to the Friendship Club and monthly visits to Primetime which is a church based community group that provides community entertainment. schools. There is a range of activities offered that reflect the resident needs including but not limited to exercises, quizzes, crafts, library visits, ball skill games, housie, walking groups, music, card games and shopping. Participation in all activities is voluntary. The DT is responsible for running the residents monthly meetings where activities feedback and residents input into the programme is encouraged.

Residents interviewed describe attending crafts and quizzes, housie, Friendship Club visits and going on outings. Woodlands has its own van for transportation of residents. The diversional therapist drives the van and has a current first aid certificate.

D16.5d:four resident files reviewed identified that the individual activity plan is reviewed when at care plan review. One rest home resident viewed had been in the facility less than six months.

##### **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:**

There is at least a three monthly review for rest home residents and dementia residents by the medical practitioner.

D16.4a Care plans are reviewed and evaluated by the clinical leader (RN) six monthly or when changes to care occur as sighted in four of five care plans sampled. One of the rest home residents have not yet been at the service for six months. There are short term care plans to focus on acute and short-term issues. STCPs show evaluation and are signed and dated by the clinical leader (RN) when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, falls, behaviours and wounds. Caregivers interviewed confirm they are updated as to any changes in resident’s care or treatment during handover sessions which occur at the beginning of each shift and this was observed during the audit.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked cupboard in the dementia unit. The dementia unity trolley has a protected bottom shelf that is not accessible to residents. The rest home uses a serviceable trolley during the medication administration time and then medications are removed and stored in the locked cupboard. Controlled drugs are stored in a locked safe in the locked cupboard in the dementia unit and two medication competent persons must sign controlled drugs out. There are two residents that have regular prescribed XXXXX one of which is currently in hospital. Weekly and six monthly stocktakes occur. The pharmacist completes a weekly check when delivering the Controlled Drugs. The service uses four weekly blister packed medication management system. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by the clinical leader (RN) and any pharmacy errors recorded and fed back to the supplying pharmacy. Five opened eye drops in the rest home and three opened eye drops in the dementia unit are dated on opening. Pain monitoring charts are kept with the medication charts including the abbey pain chart for resident in the dementia unit. There are no resident’s self- administrating medications. There are standing orders signed by the GP. Staff sign for the administration of medications on medication signing sheet. 10 administration sheets sampled correlate with prescribed instructions and have indication for use of PRNs. The medication folder includes a list of specimen signatures.

Medication profiles are legible, up to date and reviewed at least three monthly by the GP. Residents/relatives interviewed state they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Senior caregivers administer medicines and the clinical leader (RN) when required. All have been assessed as competent. One senior caregiver in the rest home and one senior caregiver in the dementia unit were observed administrating medications with correct procedure including checking the GP prescription chart and signing correctly for the medication.

 D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

**Attainment and Risk:** 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 1.3.12.3 (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:** PA Low

**Evidence:**

Woodlands cooks all food on site. There are two cooks that work on a four on and four off roster 8am-2pm. The cook interviewed has been employed at the service for six months. She has previously worked in other rest home kitchens as a cook for three years. Both cooks have completed food safety training. On the day of the audit the cook was training another staff member as a back-up cook. There are two kitchen hands that work in the evening to serve the evening meal that has been prepared by the cook. Both are currently completing food safety training. During the day caregivers help with the dishes. There is a four weekly rotating winter and summer menu. The menu has not been reviewed by a dietitian since February 2011. This is an area requiring improvement.

A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. The food is prepared in the main kitchen and served from bain marie in the rest home dining area. Meals for the dementia unit are served from the bain marie and then covered and taken to the unit. There is one chiller and two freezers. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food in the freezer and fridge is labelled or dated and stored correctly.

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents’ dietary needs are communicated to the kitchen as reported by the chef interviewed. There is home-made baking provided daily. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff. The cook reports that there are no special diets required currently but she described soft foods, moulied, and vegetarian and gluten free diets. There is a communication book that is used between the two cooks. Weights are recorded weekly/monthly as directed by the clinical leader (RN)s. Residents are invited to give feedback regarding food services at the monthly residents meetings. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted on the notice board in the kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.

 E3.3f. There is evidence that there are additional snacks nutritious available over 24 hours including sandwiches, biscuits, crackers and canned food

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Woodlands cooks all food on site. There are two cooks that work on a four on and four off roster 8am-2pm. The cook interviewed on the day of the audit has been employed at the service for six months. She has previously worked in other rest home kitchens as a cook for three years. Both cooks have completed food safety training. On the day of the audit the cook was training another staff member as a back-up cook. There are two kitchen hands that work in the evening to serve the evening meal that has been prepared by the cook. Both are currently completing food safety training. During the day caregivers help with the dishes. There is a four weekly rotating winter and summer menu. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities.

**Finding:**

The menu has not been reviewed by a dietitian since February 2011

**Corrective Action:**

Ensure that the menu is reviewed by a dietitian.

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service displays a current building warrant of fitness which expires on 30 June 2014.

##### **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:**

Woodlands has policies and procedures on restraint minimisation and safe practice. The clinical leader (RN) is the restraint coordinator and confirms that the service promotes a restraint-free environment. Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint. Policy also includes definitions for restraint and enablers. There are procedures for restraint if it should be required and associated documentation to support the policy including a restraint register, restraint/enabler assessment forms, restraint/enabler consent forms, a restraint/enabler plan of care, monitoring forms, and three-monthly evaluation forms. A restraint meeting is held six monthly. Restraint education is provided annually and was last provided for staff in June 2013.

##### **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 a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (clinical manager) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Hand hygiene (surveillance audits) are included in the audit schedule (last completed April). There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

##### **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.)*