

# Maungaturoto Residential Care Limited

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Current Status: 1 July 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

## General overview



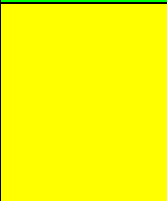

Maungaturoto Rest Home is a sixteen bed rest home located in Maungaturoto. At audit there are eleven residents living in the rest home. There have been no significant changes to the building, services provided, or staff in key roles since the last audit.

At the last audit there were fifteen areas identified as requiring improvement. All except two areas have been fully addressed. At this audit there are five areas identified as requiring improvement. These includes undertaking internal audits and linking the results with the organisation's quality indicators; corrective action planning; monitoring contractor annual practising certificates; ensuring the general practitioner documentation is available in a timely manner; and evaluating residents' progress towards achieving their goals.

## Audit Summary as at 1 July 2014

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 1 July 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 1 July 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Continuum of Service Delivery as at 1 July 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### Safe and Appropriate Environment as at 1 July 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 1 July 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 1 July 2014

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

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## 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

<b>Legal entity name:</b>	Maungaturoto Residential Care Limited
<b>Certificate name:</b>	Maungaturoto Residential Care Limited

<b>Designated Auditing Agency:</b>	The DAA Group Limited
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<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Maungaturoto Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 1 July 2014 <b>End date:</b> 1 July 2014

<b>Proposed changes to current services (if any):</b>
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<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	11
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## Audit Team

<b>Lead Auditor</b>	XXXXXXX	<b>Hours on site</b>	9	<b>Hours off site</b>	4
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<b>Other Auditors</b>	XXXXXXX	<b>Total hours on site</b>	9	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	18	Total audit hours off site	10	Total audit hours	28
Number of residents interviewed	3	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	12	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Monday, 29 July 2013

## Executive Summary of Audit

### General Overview

Maungaturoto Rest Home is a sixteen bed rest home located in Maungaturoto. At audit there are eleven residents living in the rest home including one resident who is receiving short term (respite) care. There have been no significant changes to the building, services provided, or staff in key roles since the last audit.

At the last audit there were fifteen areas identified as requiring improvement. All except two areas have been fully addressed. At this audit there are five areas identified as requiring improvement. These includes undertaking internal audits and linking the results with the organisation's quality indicators; corrective action planning; monitoring contractor annual practising certificates; ensuring the general practitioner documentation is available in a timely manner; and evaluating residents' progress towards achieving their goals.

### Outcome 1.1: Consumer Rights

The residents and family members interviewed confirm being very happy with services provided and confirm communication occurs in an open and transparent manner. There is access to interpreters should these be required.

Policies provide guidance for staff in relation to informed consent procedures. Advanced directives sighted have been developed to meet legislative requirements and now meet the requirements of the standards.

The complaints process is documented and communicated to residents and family members. There have been no complaints since the last audit.

### Outcome 1.2: Organisational Management

Maungaturoto Rest Home is managed by a nurse manager who is an experienced registered nurse with a current practising certificate. The nurse manager has been employed at Maungaturoto Rest Home for four years. The nurse manager works weekdays and is also on call. The nurse manager participates in relevant ongoing education.

The organisation has a business plan and quality and risk plan which details the vision, mission, philosophy and objectives for care. These plans includes quality indicators/goals and an internal audit programme. Internal audits are not being undertaken as scheduled and are not being linked with the quality indicators. While corrective action planning is occurring the plans are not always sufficiently detailed. These are areas requiring improvement.

Policies and procedures are developed and reviewed by an external contractor and localised to reflect the needs of Maungaturoto Rest Home. Document control processes are implemented and this now meets the requirements of the standard.

A hazard register is maintained. An organisation risk register has been developed and is reviewed. The nurse manager attends the regular board meetings and topics discussed include organisational risk. This now meets the requirement of the standards.

Appropriate incidents and adverse events are being reported by staff and are being documented and communicated to residents and/or their next of kin. This now meets the requirements of the standard. The nurse manager analyses and summarises the number and types of reported incidents/adverse events on a monthly basis and this is communicated to staff at the monthly staff meetings.

There is a very stable workforce with only one new staff member hired since the nurse manager's appointment. Policies and procedures provide the framework for recruitment and orientation of staff. Staff annual performance appraisals are current. An area requiring improvement is identified in relation to monitoring the contracted health professional's annual practising certificates. Staff participate in relevant ongoing education. Five staff have completed an industry approved qualification for dementia care.

A policy provides the framework for staffing and skill mix. There is at least one caregiver with a current first aid certificate on duty at all times.

Residents' files are stored securely. Resident records are identifiable and the date and time of documentation is now consistently recorded. The area identified as requiring improvement at the last audit now meets the standards.

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

Services are provided in collaboration with suitably qualified staff and health professionals. Time frames for service delivery are met. All residents have a care plan documented which reflects current needs and required interventions. The residents' day to day needs and wellbeing is well monitored, however an improvement is required to ensure achievement towards goals is documented during the evaluation process. The general practitioner is on site every week and conducts the required reviews. An improvement is required to ensure that a copy of the general practitioner's record is maintained in the residents' records. The previous improvements required regarding the information provided for prospective residents, pain assessments and short term care plans have been addressed.

Activities are planned to meet the needs of the resident. Individual activity goals are documented and ensure the provision of relevant and appropriate activities. Previous interests, hobbies, culture and ability is considered. Sufficient activities and outings are provided and participation in activities is voluntary.

The required medication management policies and procedures are documented and available to staff. All medications are stored securely and the previous area requiring improvement to controlled and discontinued medication have been addressed. Medications are monitored by the nurse manager and the general practitioner. All staff have completed a medication competency.

Food services are sufficient to meet the needs of all residents. Food and nutritional needs are assessed and the menu has been reviewed by a dietitian. Food preparation and storage meet food safety requirements.

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

The building has a current building warrant of fitness with an expiry date of 1 July 2015. Clinical equipment reviewed demonstrates annual performance monitoring checks are occurring. This now meets the standards. A copy of the letter from the New Zealand Fire Service approving the premises fire evacuation plan was sighted. This also now meets the requirements of the standard. Fire evacuation drills are conducted six monthly (most recently in March 2014).



## Outcome 2: Restraint Minimisation and Safe Practice

There are adequately documented guidelines on minimising the use of restraints and enablers and the previous improvement required regarding definitions of restraint and enablers has been addressed. Alternatives to restraint are in use and all staff have received sufficient training on restraint and enabler use.

## Outcome 3: Infection Prevention and Control

Surveillance for residents who develop infections is occurring. The surveillance is appropriate to the service setting. Overall infection rates are low and the results are communicated to staff via shift handovers and the monthly staff meeting. The nurse manager reports being well informed when caregivers suspect a resident has an infection and the general practitioner is also informed. A suspected outbreak of Norovirus occurred in February 2014. The nurse manager advises she reported this as an essential notification to relevant authorities.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	18	0	3	1	0	0
Criteria	0	40	0	3	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	28
Criteria	0	0	0	0	0	0	0	56

## 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 Moderate			
HDS(C)S.2008	Criterion 1.2.3.7	A process to measure achievement against the quality	PA Moderate	Internal audits are not being undertaken as scheduled or linked	Implement the internal audit schedule and monitor quality	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and risk management plan is implemented.		with the organisations identified quality indicators. Only one internal audit has been completed in 2014 to date.	indicators as identified within the quality and risk programme	
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 Moderate	Whilst corrective action planning is occurring, corrective action plans are not sufficiently detailed to identify the areas for improvement and or actions to be undertaken. As an example there are between two and nine incident reports each month between March 2014 and June 2014 related to medication reportable events. While discussion has occurred during staff meeting non-compliance with policy is still regularly occurring.	Ensure that corrective action plans are developed when areas are identified as requiring improvement. Ensure that that these plans are sufficiently detailed to identify the required improvements, and that the plans are implemented and monitored for effectiveness.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.2	Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Current annual practising certificates are initially not available for the pharmacist and the dietitian. A copy of these APCs are obtained during the audit.	Develop a process to monitor and ensure registered health professionals who provide resident services have a current annual practising certificate.	180
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Records of GP visits are not consistently maintained within the residents' files.	Maintain records of GP reviews and assessment within the residents' files.	180
HDS(C)S.2008	Standard 1.3.8:	Consumers' service delivery	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Evaluation	plans are evaluated in a comprehensive and timely manner.				
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	Evaluations including progress towards goals are not documented.	Document evaluations, including achievement towards goals.	180

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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:**

The open disclosure policy identifies that a frank discussion with residents and their support person related to adverse events must be undertaken. Four of four caregivers and the nurse manager interviewed can describe open disclosure and how this occurs. This may be undertaken by the caregiver or the RN depending on the situation being disclosed. All three residents and the two family members interviewed verify they are kept informed of all relevant issues in a timely manner. This is verified during review of six of six incident reports reviewed at random and in the five resident files reviewed by the second auditor.

The interpreter policy identifies residents have the right to have access to interpreter services. The nurse manager (NM) confirms that all current residents are able to communicate effectively in English. Interpreter services would be obtained if required by contacting the Northland District Health Board (NDHB).

The aged related residential care (ARRC) 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.

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

**Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The previous improvement regarding the validity of consents has been addressed. Valid consents and advance directives are sighted in five out of five resident records sampled.

**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

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

### Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

The complaints policy identifies that all complaints are to be documented, followed up and trends analysed in order for corrective actions to be taken as appropriate.

The complaints and compliment form and the complaints register is sighted at audit. There have been no complaints received since the last audit. The complaint via the Health and Disability Commissioner that was under investigation at the last audit has now been closed. The rest home was not found in breach of the Code, however an observation was made in relation to improving documentation.

Four of four caregivers interviewed are aware of their responsibilities in relation to complaints. Staff advise any concerns raised by residents and or family are addressed at the time proactively. This would include events such as, the cup of tea not being hot enough, or the resident wanting cares completed at a different time. The caregivers report any complaint would be reported to the NM but cannot recall receiving any complaints in recent times.

All three residents and two family members interviewed confirm they are aware of the complaints process and have no complaints about services provided. Complaints information is included in information pack given to residents and their family/whanau upon admission.

ARRC 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:**

The service mission statement is shown in the business quality and risk plan (dated 4 October 2013) and policy. This is 'to provide a quality homely environment in which the frail elderly and / or confused elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of race, culture and creed'. The philosophy includes nine components. There are nine identified nursing objectives which include maximising residents' independence and establishing links with tangata whenua. The business quality risk and management plan identifies the scope, goals and service philosophy (sighted). The NM advises monitoring of the process towards achieving these goals, objectives and meeting the organisation's stated philosophy is undertaken via the complaints and compliments process, monthly staff meetings and discussions with resident and family members. The internal audit programme is also one of the mechanisms reported to monitor progress. These audits are not being completed and is raised as an area for improvement in 1.2.3.7.

The nurse manager has been employed at Maungaturoto Rest Home (MRH) for four years. She was employed as the RN for approximately six months before being appointed to the role of nurse manager (NM). The NM has a current annual practising certificate (APC) and this is sighted. The NM's job description details the NM's roles and responsibilities and meets the requirement of the ARRC contract. The NM is an approved assessor for Careerforce. The NM has attended more than eight of hours of education in the last year on clinical and management topics and this includes having completed interRAI training and the associated competencies. The NM regularly attends the monthly board meetings and this is verified in the minutes sighted.

The requirements of the ARCC contract 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 Moderate

#### **Evidence:**

The quality and risk plan incorporates goals and objectives related to consumer focus, provision of effective programmes, certification and contractual requirements, risk management and has a stated intent of having a continuous improvement focus to service delivery. The aims and objectives of quality activities are described in the policy documents sighted. The corrective action process is detailed. While corrective action plans are being developed they are not always sufficiently detailed and include all relevant areas. This is an area requiring improvement.

Policy and procedures are provided by an external quality consultant. Emails verifying the NM at MRH is receiving updated policies from the consultant on a regular basis is sighted. The consultants email summarises what changes have been made to the attached policy documents during the current review or whether the documents are new. The NM has reviewed the policy manual documents - as sighted during audit - in the last 12 months. A review and amendment log notes the reviews and changes that have been made to individual documents. A new policy on managing head injuries was emailed to the NM in May 2014. This has been printed and is in the policy manual. The footer has been detailed to include the date of issue (14 May 2014) and the version number. Copies of the new neurological monitoring forms is available for staff use. Document control processes are implemented. The area identified as requiring improvement at the last audit now meets the standards.

The four caregivers interviewed confirm that staff are advised of quality and risk activities at shift handover and via the monthly staff meetings. Minutes of the monthly staff meetings are sighted for 7 April 2014, 5 May 2014 and 9 June 2014. Minutes reflect discussions on documentation, managing indwelling urinary catheters (and follow-up of concerns), a new definition of falls (as per interRAI), staffing, ensuring open disclosure is occurring, safety issues, influenza vaccinations, residents with infections, training/education, organisation processes/policy requirements, individual resident care issues and a summary of the reported incidents for the past month. The use of restraints and enablers for resident care is also discussed.

Processes are in place to monitor and report hazards and remedial action is being undertaken. A hazard register is sighted. A caregiver is also the health and safety (H&S) representative. During interview the Health & Safety representative advises being responsible for reviewing the organisation hazards register. This includes monitoring the quantity and ensuring storage of chemicals. There is also an organisation risk register. This includes (but is not limited to): financial, clinical care/resident safety, staffing, disasters and the facility/environment. The NM reports to the board on quality and risk issues via monthly meetings. Minutes of meetings sighted includes discussion on relevant topics. The area identified as requiring improvement at the last audit now meets the standards. Actual and potential risks are identified, documented and are communicate to all relevant staff.

Quality and risk is monitored via accident/incident forms, monitoring residents for infection, complaints and compliments reporting, audits and via staff meetings. Internal audits are not being undertaken as scheduled or linked with the organisation's quality indicators. This continues to be an area requiring improvement.

ARRC contract requirements are met excluding D 19.4 b and d.

**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:** PA Moderate

**Evidence:**

There are documented quality indicators sighted. Each item shows a goal with a method measure, tolerance level for compliance and an area for the results to be documented. The 2014 audit schedule sighted is the mechanism for the quality indicators to be monitored. The internal audit schedule details what audits are to be undertaken and when. Only one audit has been completed in 2014 to date and this occurred in January 2014. This audit evaluated one resident's satisfaction with services six weeks after admission. Monitoring implementation of the quality and risk programme is an area that continues to require improvement. This was raised in 1.2.3.6 at the last audit.

**Finding:**

Internal audits are not being undertaken as scheduled or linked with the organisations identified quality indicators. Only one internal audit has been completed in 2014 to date.

**Corrective Action:**

Implement the internal audit schedule and monitor quality indicators as identified within the quality and risk programme

**Timeframe (days):** 90 (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 Moderate

**Evidence:**

While corrective action planning is being undertaken it is observed at audit there are a number of medication related events being reported (refer to 1.2.4). These primarily relate to medications not being signed as administered. The corrective action plan is insufficiently detailed in relation to these events. While staff training was provided at a staff meeting this has not proven to be effective as the number of incident reports in relation to this topic are significant. Staff medication competencies were last assessed in November 2013.

Corrective actions are being taken in response to residents' falls or other injuries as evidence in the five residents' files sampled during audit.

**Finding:**

Whilst corrective action planning is occurring, corrective action plans are not sufficiently detailed to identify the areas for improvement and or actions to be undertaken. As an example there are between two and nine incident reports each month between March 2014 and June 2014 related to medication reportable events. While discussion has occurred during staff meeting non-compliance with policy is still regularly occurring.

**Corrective Action:**

Ensure that corrective action plans are developed when areas are identified as requiring improvement. Ensure that that these plans are sufficiently detailed to identify the required improvements, and that the plans are implemented and monitored for effectiveness.

**Timeframe (days):** 90 (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 open disclosure policy states that adverse events will be discussed with the resident and family/whānau. This is sighted to be implemented at audit for all six resident related adverse events reviewed during audit. A review of the residents' progress notes confirms these events are being documented and family are being informed. The area identified as requiring improvement at the last audit now meets the standards.

All incidents and accidents are required to be documented. The health and safety policy (September 2012) identifies the process for notification of accidents and all four caregivers interviewed are able to describe their reporting responsibilities and the type of events reported. The number and type of incidents are summarised on a spread sheet each month. The number and type of adverse events are discussed at the monthly staff meeting and this is verified as occurring in the three months minutes reviewed during audit. Whilst corrective action planning is occurring in relation to reported events, this is not always sufficiently detailed or effective and is raised as an area requiring improvement in 1.2.3.8.

The 'Notice of uncontrollable event' form sighted, details some of the events that would be reported via essential notification including workforce shortage, outbreak, pandemic, loss of power/water/essential service, flood or disaster, industrial action and other events. The NM advises there has been one event requiring essential notification since the last audit. This was a suspected outbreak of Norovirus in February 2014. The NM is able to identify the other types of events that would be notified including serious harm events, police investigations, controlled drug issues and the unexpected death of resident.

ARRC 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:**

There are documented processes for the recruitment of staff which includes the need to undertake references checks, conduct interviews and verify experiences and qualifications (where applicable). The NM advises there has been one new staff member employed since her employment. There is a very stable workforce. Performance appraisals are required to be undertaken annually. A current performance appraisal is present in all four staff files reviewed at audit (where the employee has been working for more than 12 months), and in the NM file. The NM performance appraisal was undertaken in December 2013 by a member of the board and is documented as being the 'charge person audit'. The nurse manager is noted to be 100% compliant with requirements.

Documentation identifies that new staff undertake an induction which matches their position description. The staff training, orientation and induction process sighted and includes orientation to the facility, policies and procedures, emergency management procedures and individual resident needs. The orientation programme has been completed for the new employee whose records are reviewed.

The NM has a current annual practising certificate (APC) and this is sighted. A copy of the GP's APC is also sighted at audit. The APC for the pharmacist and dietitian on file had expired on 31 March 2014 and had not been rechecked. Monitoring of staff and contractors APCs is an area continuing to require improvement. A copy of the pharmacy license to operate is also on file.

There is an education programme provided for staff. This includes in-service, competency assessments and attending off site study days. MRH is participating in an external consultants online education programme. The NM has downloaded in-service education sessions for the year onto a disc. The staff training programme is detailed for the year on the office whiteboard with a topic every month. The education includes the requirements of these standards and the ARRC contract. Attendance records are being maintained. The education attendance records sighted for the past 15 months includes (but is not limited to): food safety, medication competency, managing challenging behaviour, palliative care, enduring power of attorney, diabetes, Parkinson's disease and restraint minimisation. Eight staff completed food hygiene and safety training in February 2014. All staff have a current first aid certificate and certificates of completion sighted. Staff have attended a fire evacuation drill in the last 12 months. Five staff have completed an industry approved qualification in dementia care (via Careerforce) and records of this are sighted.

ARRC contract requirements met excluding D 17.1 bii.

## 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:** PA Low

### **Evidence:**

The NM has a current annual practising certificate and this is sighted. A copy of the GPs (APC) is sighted at audit and is current. The NM obtained a copy of the pharmacist and dietitian APC during audit. The documents on file are dated as expiring 31 March 2014. This continues to be an area requiring improvement.

A copy of the drivers licence for the NM and previous activities co-ordinator is also sighted. A different caregiver is now responsible for activities. The NM advises this caregiver will not be transporting any residents so a copy of the driving licence is not required for the staff member's file. The activities person interviewed confirms that driving residents is not required for this role.

**Finding:**

Current annual practising certificates are initially not available for the pharmacist and the dietitian. A copy of these APCs are obtained during the audit.

**Corrective Action:**

Develop a process to monitor and ensure registered health professionals who provide resident services have a current annual practising certificate.

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

**Criterion 1.2.7.3 (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 organisation's policy identifies that the staffing of a rest home will have at least one staff member on duty for 10 or less residents and from 10 to 29 residents one staff member on duty and one on call.

The NM works weekdays at least 40 hours per week and is on call when not on site except every second weekend when a senior caregiver is noted on call. The senior caregiver is the first point of call for questions or concerns, however will contact the NM if she is required. Interview with a senior caregiver who undertakes the on call services identifies that she would assist staff in the event a client had a fall, skin tear or if the workload is high. The NM would be called if there are any medication related issues, a death of a resident, any family or resident concerns, if a resident had an injury following a fall and if there are any other events that the NM would otherwise need to be informed. The NM attends as required otherwise provides advice over the phone.

There is a caregiver roster on duty each shift seven days a week. Where there are 10 or more residents receiving care a 'short shift' has been introduced for the morning and the evening. An additional caregiver works 7 am to 9 am 7 days a week and 5pm to 7.30 pm to assist with meal times and helping the residents get ready for bed. These hours are allocated on a separate short shift roster which is sighted.

Caregivers undertake cleaning and laundry duties weekdays. On the weekend a caregiver is employed for three hours each day to undertake cleaning duties (overall 12 hours per fortnight) and primarily cleans the resident's bedrooms when they go out with family. The NM and four caregivers at interview confirm the NM is available on call, is contactable and always attends when required. The caregivers cover each other's shift in the event of leave or other unplanned absences.

The maintenance man is on call seven days a week and a gardener undertakes gardening duties three days a week. One hour is provided for the activities programme on Monday, Wednesday and Fridays each week. The cook is rostered to work between 8am to 1 pm seven days each week.

All three residents and two family member interviewed confirm care is always provided in a timely manner to meet individual resident's needs.

ARRC 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.)

**Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

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

**Attainment and Risk:** FA

**Evidence:**

The previous improvement regarding the management of health records has been sufficiently addressed. All records included in the sample have the name of the resident and the date of entry. The name and designation of the writer is recorded. There is no evidence of correction fluid. Medication administration charts sampled include the date of administration.

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## 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 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

**Attainment and Risk:** FA

**Evidence:**

The previous improvement regarding the information provided to prospective residents has been adequately addressed. The rest home pamphlet is sighted and provides prospective residents' with accurate detail regarding the current services provided. Entry criteria and screening process are clearly documented in the organisations policies and procedures. All residents sign a service agreement on entry with defines the services provided and (where applicable) any additional charges. Signed service agreements are sighted in records sampled and residents interviewed confirm they received sufficient information on entry

The District Health Board requirements are met.

### Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

**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 1.3.3: 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:**

Residents and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. Five residents' files are sampled. All assessments and care plans are developed and reviewed by the Nurse Manager, and daily interventions and support with activities of daily living are implemented with the help of trained caregivers. Care plans are detailed and include physical, spiritual and cultural abilities, deficits and expected outcomes. For those who have been assessed using the interRAI assessment tool, the related care plans include the required triggers.

Timeframes for service delivery are defined. An initial assessment is performed on admission by the Nurse Manager and a medical assessment is required to be conducted by the general practitioner (GP) on entry, however records of medical assessments and reviews are not consistently kept within the residents' files and an improvement is required in relation to this.

An initial care plan is developed and implemented for the first three weeks to guide staff. Following this the long term care plan is developed and implemented to meet the identified needs and goals of the resident. GP medication reviews are completed every three months and this is confirmed in interview with the GP. The GP interviewed also confirms involvement in specialist referrals and medication reviews and states that they are always contacted regarding any concerns in a timely and proficient manner.

Continuity of care is maintained between the organisation and the general practitioner. Daily handovers are conducted between staff during shift handovers. All staff have access to the current care plan and this is confirmed in interview with staff.

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

The District Health Board requirements are partially met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The GP is onsite each week. The GP works from the medical centre which is next door to the rest home. It is noted that records of the GP medical assessments are not consistently held in the residents' integrated files. The GP is interviewed and reports that records are documented and held at the medical centre. This was addressed on the day of the audit and it was agreed that records of medical reviews will be forwarded to the rest home as required.

**Finding:**

Records of GP visits are not consistently maintained within the residents' files.

**Corrective Action:**

Maintain records of GP reviews and assessment within the residents' files.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

**Attainment and Risk:** FA

**Evidence:**

The previous improvement regarding pain assessments has been adequately addressed. There are three residents who are currently on regular pain relief medication. A current pain assessment is sighted in each of the residents' files. This includes an updated interRAI assessment, and associated triggers. Comprehensive assessments are completed on entry, within the required timeframes. These are reviewed as required and updated if needed. Current assessments are sighted in all resident records sampled.

### Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

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

**Attainment and Risk:** FA

**Evidence:**

The previous assessment regarding the use of short term care plans has been sufficiently addressed. Short term care plans are sighted where required. This includes short term care plans for wounds and infections. Short term care plans are signed off by the Nurse Manager once the condition has resolved.

Sufficiently documented care plans are sighted in all records sampled. These include a nursing goal and the required interventions. Care plans include the required domains as per the District Health Board contract.

The District Health Board requirements are met.

**Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Interventions are documented within each domain of the care plan. Interventions sighted are sufficient to address the nursing diagnosis and goals. For example pressure area care is in place for a resident who is unable to mobilise and a 24 hour care plan is in place for residents with dementia. Base line observations and routine monitoring is conducted where required. Care plans based on the interRAI assessments are now in place for five residents, and the required interventions are documented for the triggers identified. The GP reports confidence that all prescribed interventions are implemented as required. Residents interviewed report they are encouraged to be involved in developing realistic and optimal levels of functioning to meet their own everyday living needs/goals and to maintain independence. This is also confirmed in interviews with two family members.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Sufficient activities and outings are provided for the 10 residents. Activity assessments are completed on entry. This includes previous interests, hobbies, culture and ability. The activities programme reflects that independence is encouraged and choices are offered. Some residents access activities in the community independently and others are supported to do so. An activities board is displayed which includes the regular activities which are provided in the home. There is a dedicated activities person on site three hours per week. The activities person is interviewed. Daily records of participation in activities are maintained.

Residents and family members interviewed confirm that sufficient activities are provided and access to the community is supported.

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 plan reviews are conducted in an on-going manner and daily progress records are completed by the caregivers. Any changes to support interventions are documented and the care plan updated accordingly. All five care plans sampled are current.

In addition a six monthly evaluation of goals and interventions is conducted by the Nurse Manager at which point the previous care plan is archived and a new one documented, however records of evaluations have not been maintained and an improvement related to this is required.

Three monthly GP reviews are also evident in 10 out of 10 residents' medication files sampled. The GP interviewed states that a more comprehensive process for review has commenced which involves set days and notification to the family in order for them to attend. The two family members interviewed stated they have been involved in the 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:**

The Nurse Manager develops a new care plan every six months and removes the previous plan from the residents' records. There is no documented record that a review has occurred which includes achievement towards goals.

**Finding:**

Evaluations including progress towards goals are not documented.

**Corrective Action:**

Document evaluations, including achievement towards goals.

**Timeframe (days):** 180 (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:**

There are adequately documented policies and procedures for all stages of medicine management. The medicines management protocol includes standing orders, resident self-medication, responsibilities for each stage of the medication process, and medication reconciliation. Policies reflect legislative requirements and safe practice guidelines. There are emergency protocols to cover angina, the giving of nitro lingual spray and the giving of pain relief and standing orders are documented for the administration of medications, such as laxsol, paracetamol and ural.

A blister pack medication system is implemented for all regular medications. All medicines are prescribed by the GP using the pharmacy generated medication chart. The service has one GP. All medication charts include photo identification and allergies. Three monthly GP reviews are evident in 10 out of 10 medication records sampled.

Medications are safely stored in a locked medication trolley in the Nurse Manager's office. The trolley is taken out during the administration round. Non packaged medication is individually prescribed and labelled.

There is currently one resident prescribed a controlled drug. Controlled drugs are securely stored in a locked cupboard in the Nurse Manager's office. The required checks of controlled drugs have been maintained. The previous finding regarding controlled drug checks and discontinued medication has been sufficiently addressed.

Medications are administered by the caregivers. The previous finding regarding medication competencies has been addressed and all staff completed competencies in November 2013, however a number of medication errors have occurred since (predominately forgetting to sign the administration chart) and there is insufficient evidence that the required corrective actions had been implemented. An improvement is documented in criterion 1.2.3.8. The administration process is observed during the audit and meets requirements.

There are currently no residents who self-administer any medications.

The District Health Board requirements have been met.

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

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

**Attainment and Risk:** 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:** FA

**Evidence:**

Policies and procedures identify how the service meets residents' nutritional needs. A four week menu is rotated. The menu has been approved by a registered dietitian who confirms it is appropriate to the needs of the older person (2012). There has been no changes to the menu since the last review. The cook interviewed states that deviation to the menu only occurs when local community members donate fresh garden produce, and a record of this is maintained.

Individual nutritional assessments are completed on entry. Special dietary needs are identified, including allergies, likes and dislikes of each resident. There are currently no residents requiring special diets. Special equipment is available if needed. Residents' nutritional status is monitored and residents are weighed every month. Three out of three residents and two out of two family members interviewed are very satisfied with the food.

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. Guidance is provided on food hygiene principals and kitchen staff have the required food safety qualifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building has a current building warrant of fitness with an expiry date of 1 July 2015. A current electrical safety test and tag label is present on electrical equipment sighted with an expiry of 26 January 2017. The two hoists have been serviced on 6 May 2014. Other clinical equipment including the scales, tympanic thermometer and blood

pressure checking equipment have evidence of current performance monitoring checks last completed on 6 August 2014. Fire safety equipment has been most recently checked in June 2014. The area identified as requiring improvement at the last audit now meets the standards.

**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.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:** There is an approved fire evacuation plan which is sighted. A letter of approval from the New Zealand fire Service is dated 27 April 1999. The area identified as requiring improvement at the last audit now meets the standards.

Fire evacuation drills occur six monthly. The most recent drill occurred on the 10 March 2014 and records of completion are sighted.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(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

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### 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:**

There are sufficiently documented policies on the minimisation of restraint and the use of enablers and the previous improvement regarding definitions of restraint and enablers has been addressed. There is currently one restraint (bed rail) and one enabler (a floor mattress). The required assessments, consents, monitoring and reviews are documented. All staff receive training on the definitions and use of restraint and enablers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**



**Corrective Action:**

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

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

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### **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:**

Policy states that surveillance activities are undertaken to meet Health and Disability Services Standards requirements.

Surveillance for residents who develop infections is occurring. The surveillance is appropriate to the service setting. Overall infection rates are low and the results are communicated to staff via shift handovers and the monthly staff meeting. The NM reports being well informed when caregivers suspect a resident has an infection and the general practitioner is also informed. A suspected outbreak of Norovirus occurred in February 2014. The NM advises she reported this as an essential notification to relevant authorities.

Three of three caregivers confirm they are responsible for reporting all residents with suspected infections to the NM and or GP. The NM is responsible for verifying the data and analysing and reporting the infection rates to staff. This includes via shift handover at the time and infection is diagnosed and well as three monthly when full analysis, rates and trends are presented at the staff meeting. The infection control quarterly reports for October 2012 to December 2012 and January 2013 to March 2013 sighted and also referenced in the staff meeting minutes sighted.

The GP interviewed confirms he is always advised in a timely manner when residents are suspected of having infections.

### **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.)*