

Y&P NZ Limited - Eden Rest Home

Current Status: 14 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

Eden Rest Home is a 17 bed rest home located in Mt Eden Auckland. At audit there are 15 residents receiving care. The majority of residents do not speak English. Since the last audit the facility manager has gone on extended leave. A new manager is employed two days a week. The owner is on site every day and is responsible for day to day operations. A new registered nurse was employed in January 2014. A new activities person has been employed who is also the manager's assistant. An additional bedroom has been installed combining the previous nurses' station and the public bathroom.

At the last audit there were nine areas identified as requiring improvement. All these have been addressed. At this audit there are four areas identified as requiring improvement. These are in relation to: the analysis of incident/adverse events; electrical safety testing and tagging and performance monitoring of clinical equipment; the new bedroom which does not meet required standards; and ensuring the resident fire evacuation register is accurate and a staff member with a current first aid certificate is on duty at all times.

Audit Summary as at 14 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

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

Consumer Rights as at 14 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 14 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 low risk.
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Continuum of Service Delivery as at 14 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 14 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.		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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Restraint Minimisation and Safe Practice as at 14 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 14 July 2014

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

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Y&P NZ Limited
Certificate name:	Y&P NZ Limited - Eden Rest Home
Designated Auditing Agency:	The DAA Group Limited
Types of audit:	Surveillance Audit
Premises audited:	Eden Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 July 2014 End date: 14 July 2014

Proposed changes to current services (if any):

Eden Rest Home has created a new bedroom by combining the space used previously for the nursing station and the public toilet. There is a window and call bell present in this room. The room is currently not suitable for resident use as an open toilet is present in the corner of the bedroom directly in front of the main entrance into the bed room. An area for improvement has been raised in relation to this in 1.4.2.4.

Total beds occupied across all premises included in the audit on the first day of the audit:	15
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Audit Team

Lead Auditor	XXXXXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXXXXX	Total hours on site	8	Total hours off site	4
Technical Experts	XXXXXXXXXXXX	Total hours on site	1	Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	17	Total audit hours off site	10	Total audit hours	27
Number of residents interviewed	5	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	8	Total number of staff (headcount)	12	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

Dated

Executive Summary of Audit

General Overview

Eden Rest Home is a 17 bed rest home located in Mt Eden Auckland. At audit there are 15 residents receiving care. The majority of residents do not speak English. Since the last audit the facility manager has gone on extended leave. A new manager is employed two days a week. The owner is on site every day and is responsible for day to day operations. A new registered nurse was employed in January 2014. A new activities person has been employed who is also the manager's assistant. An additional bedroom has been installed combining the previous nurses' station and the public bathroom.

At the last audit there were nine areas identified as requiring improvement. All these have been addressed. At this audit there are four areas identified as requiring improvement. These are in relation to: the analysis of incident/adverse events; electrical safety testing and tagging and performance monitoring of clinical equipment; the new bedroom which does not meet required standards; and ensuring the resident fire evacuation register is accurate and a staff member with a current first aid certificate is on duty at all times.

Outcome 1.1: Consumer Rights

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Evidence is seen of informed consent and open disclosure in residents' files reviewed. Communication channels are clearly defined and interviews and observation confirm communication is effective.

The complaints process is communicated to residents and family members. Complaints are investigated and actively managed. Communication with the complainant is documented and now meets the intent of the standards.

The previous areas for improvement relating to informed consent, advance directives and the identifying of additional costs in the admission agreement have been addressed.

Outcome 1.2: Organisational Management

One of the rest home owners is now responsible for day to day operations. The owner purchased this resthome in 2012 and has previously worked in aged care services in New Zealand. The owner participates in ongoing training related to managing an aged care facility. A new registered nurse has been

employed in January 2014 and is on call when not on site. Eden Rest Home has identified the values, goals and philosophy of care. This is documented in a business plan and reviewed on at least a three monthly basis.

The quality and risk management systems in use has been developed by an external consultant and localised to reflect the needs of Eden Rest Home. The quality and risk programme includes policy and procedures, compliments and complaints, incident/accident reporting, internal audits, and identification and management of hazards and risk. A formal meeting occurs on a three monthly basis and this is where quality and risk information is analysed and discussed. Where applicable, corrective actions are planned by Eden Rest Home, implemented and monitored for effectiveness. Whilst there is analysis of adverse events/incidentts the data is not always accurate and this is an area requiring improvement. Eden Rest Home participates in an external benchmarking programme for residents with infections and incidents/accidents.

Staff are provided with an appropriate orientation programme. There are currently no volunteers. The area identified as requiring improvement at the last audit in relation to ensuring volunteers are provided with orientation now meets the standards. There is an ongoing relevant training provided for staff which is well attended.

There are documented guidelines, which are seen to be implemented, that detail staffing levels and skill mix.

Residents' records are documented in accordance with current accepted standards and are now maintained in a secure manner. The area identified as requiring improvement at the last audit now meets the standards.

Outcome 1.3: Continuum of Service Delivery

The provision of services is delivered by suitably qualified and experienced staff. The registered nurse (RN) conducts the initial assessment and initial care plan on the resident's admission to the service. The provision of care is based on the assessed needs of the resident, for residents at rest home level of care. The previous area requiring improvement to ensure all residents have an up to date Needs Assessment and Service Coordination (NASC) assessment has been addressed.

The activities are planned to meet the needs and strengths of the residents.

The menu is reviewed by a dietitian as suitable for the older person living in a care facility.

A safe medicine management system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. The previous areas for improvement, relating to a specimen signature log and records of residents who self-medicate, have been completed.

Outcome 1.4: Safe and Appropriate Environment

Eden Rest Home now has 17 single bedrooms which all have windows of natural proportion and a call bell. The newly created bedroom has an exposed toilet in the corner of the bedroom and this requires improvement.

The building has a current warrant of fitness and ongoing checks required to maintain the building warrant of fitness are being undertaken. Electrical safety checks of electrical equipment are overdue. Clinical equipment is also overdue for performance monitoring checks. These are areas requiring improvement.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Staff are reporting incidents and these are investigated and corrective action plans initiated. The number and type of incidents in the analysis is not always correct. There have been two falls coded as the resident having had a fracture which is not correct. One medication error is not included in the monthly totals for January to March 2014. Another fall noted in the incident benchmarking data is not noted on the incident register in January 2014.	Ensure the analysis, reporting and benchmarking of adverse event data is accurate	180
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply	PA Low	The test and tagging of electrical appliances was due for review	Ensure electrical equipment in use has	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		with legislation.		on 7 July 2014. This was last completed in 2012. The annual performance monitoring of clinical equipment is overdue. It was last completed in April 2013.	current test and tag labels. Ensure annual performance monitoring is occurring of clinical equipment.	
HDS(C)S.2008	Criterion 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.	PA Low	Eden Rest Home has applied for approval for another resident bedroom to be certified. This room amalgamated what was previous the nursing station and a public toilet. Whilst there is a call bell present and window of natural proportions; there is also a toilet present in the corner of the bedroom that is open/exposed. The toilet is directly in front of the bedroom door from the corridor.	Ensure the toilet is suitably contained in the additional room for which approval has been sought.	180
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	At audit the resident board and the fire evacuation list contains the names of two residents discharged on the 29 June 2014 (16 days prior to this audit). The resident's names are also still noted on the bedroom doors. A new staff member has been employed to work night shift three days a week. This staff member does not have a current first aid certificate and is in on shift as a sole employee.	Ensure the resident list and fire evacuation list is kept current. Ensure a staff member with a current first aid certificate is on duty at all times.	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 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) in the admission pack. Brochures and posters are on display and are accessible to all personnel entering Eden Rest Home. This information is also included in the resident's information booklet, as is a copy of the complaints procedure, that is handed out to all admitted and prospective residents, prior to admission. A list of interpreters is available through the Auckland District Health Board (ADHB) should assistance be required to provide the information in a language and format that is suitable.

The previous area for improvement relating to the admission agreement not documenting which areas of care may incur extra costs has been addressed.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

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 1.1.9: 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:

Interpreter service contact details are shown in the admission agreement and the resident information booklet. The Health & Disability Services advocate participates in staff education on the Code of Health and Disability Services Consumers' Rights. This is evident on the staff training schedule reviewed for 2014.

All residents have their own rooms except for one shared room which is used for a couple. Staff interviewed state they are able to communicate effectively and privately any information required with residents. The five of five residents interviewed (with assistance of an ADHB interpreter) verified that communications are managed effectively by staff. All staff, except one, speak Mandarin or Cantonese and are able to communicate easily with the residents. The staff member who cannot speak the language works with other staff who can speak the language that residents understand. The doctor visits residents in their own individual room and this ensures privacy is maintained.

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 1.1.10: 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

Attainment and Risk: FA

Evidence:

Informed consent is evident in observation of day to day activities of the staff on the day of audit. Four of four files reviewed contain evidence of informed consent forms signed on admission. All medicine charts have residents' photographs for identification.

An advance directive enables a resident to choose if they would like: antibiotics for a chest infection; resuscitation in the event of cardiac, respiratory or cerebral collapse; and active medical treatment to prolong life. The advance directive is filled out in consultation with the resident's doctor, with consent or non-consent to be revoked at any time. Four of four files have signed advance directive forms completed correctly. Staff receive education on informed consent and the Health and Disability Commissioners Code of Rights annually. Admission documentation clearly identifies inclusions and exclusions in service.

Four of four files show evidence of residents being actively involved and included in care, food, fluids, activity, outings, requests for doctors, treatments, interventions and specialist treatment.

The previous areas for improvement relating to an informed consent form being translated in both English and Chinese and the correct advance directive form being completed have been addressed.

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

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

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: <p>The resident rights policy notes residents have the right to complain and complaints must be acted upon, where possible, to address the issue immediately. Complaint outcomes are to be recorded on the reverse of the complaints form. The complaints form details that complaints must be acknowledged within 5 working days. Other timeframes documented meet the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>A complaints register is maintained. Eden Rest Home is able to evidence that the complainant is informed of complaint outcomes and this now meets the standard. Corrective action plans are implemented.</p>

The owner advises there have been no complaints from the Health and Disability Commissioner (H&DC), Ministry of Health (MoH) or District Health Board (DHB) since the last audit.

Two of two staff interviewed and the activities facilitator/manager's assistant (AF/MA) are aware of their responsibilities in relation to the reporting and management of complaints. The AF/MA is responsible for investigating and responding to complaints in consultation with the owner.

Five of five residents interviewed, with the assistance of an interpreter, confirm being aware of the complaints process and are very happy with services provided.

The aged related residential care (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 organisation's management policy was developed by an external consultant and localised to reflect the needs of Eden Rest Home. The scope of service is rest home level care. The mission statement, as documented in the residents' rights policy is 'we aim to provide a quality environment where the frail elderly (and/or confused elderly) may live and enjoy respect and friendliness with their physical, social and mobility needs met regardless of race, culture or creed. We want this to be a home where those in our care may enjoy activities and experience happiness together'. The philosophy of care includes the 'Spark of life', to identify and meet unmet needs, and the Eden philosophy of care'.

The organisation's values, includes the sacredness of life, love and compassion, valuing people, respect, integrity and honesty, acceptance and family and community.

The goals of the organisation for 2013-2014 are documented and includes (but is not limited to):

- preventing falls and injuries (keeping the falls rates under the benchmarking parameters)
- monitoring all incidents
- ensuring safe staffing

The business and strategic plan for Eden Rest Home is sighted for the period 2012 to 2015 and details the organisation's mission, history and goals. The barriers to achieving the goals are identified as well as the supporting factors which are being implemented to reduce the risks. The organisation has documented what success through the eyes of staff, funders and the community looks like as well as problems/negative indicators for each of these groups.

Quality indicators and benchmarking of data including (but not limited to) infection rates, falls, development of ulcers, complaints, unintended weight loss and hospital admissions are included in the benchmarking programme. The benchmarking programme reports events per 1000 resident days. Monitoring of the organisation's performance towards meeting the objectives, and business/strategic directions of Eden Rest Home is monitored via the service review meetings (three monthly) and benchmarking of quality indicators. This is verified via review of the last two meeting minutes.

The owner is now responsible for the day to day operations of the rest home with the support of the manager who works 20 hours a week and other staff. The owner (and spouse) have owned the rest home since 2012. Prior to this the owner worked as a caregiver and team leader in another aged care facility in Auckland for approximately five years. The owner has attended more than eight hours of education related to managing an aged care facility as required by the ARRC contract. This includes attending the quality consultant facilitated training days and the DHB residential care manager seminars. Certificates of attendance sighted. Other training is detailed in the manager's education register. The manager has a current first aid certificate and this is sighted.

A new RN was employed in January 2014 and works in this rest home and the other facility owned by the Eden Rest Home owners in a fulltime role. The RN is on call when not on site. This is verified during interview with the owner, the RN and two of two caregivers interviewed and review of the current roster. The RN has a current annual practising certificate which is sighted. The RN has worked in a variety of health settings nationally and internationally. The RN has over 16 years' experience in intensive care services in Hong Kong and the United Kingdom as detailed by the RN during interview and noted on the RN curriculum vitae which is sighted. The RN has worked in the residential aged care sector in New Zealand since 2011 and this included a senior leadership role. The RN has a job description which details the roles and responsibilities for the RN role.

The ARRC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The quality plan includes:

- having current policies and procedures available for staff
- resident surveys (including meals and general satisfaction)
- complaints/compliments monitoring and management
- internal audits
- hazard identification and management
- accident and incident reporting
- monitoring bed occupancy
- monitoring residents requiring admission to the hospital and reasons for this
- civil defence and emergency planning
- monitoring residents with infections, episodes of challenging behaviours, medications adverse events and falls
- monitoring staff accidents/injuries
- monitoring safe staffing
- staff training/ongoing education

Policies and procedures are developed by the external quality consultant and localised to reflect the needs of Eden Rest Home. All policy documents sighted during document review have a version number, and the pages are numbered. The policy documents sighted are dated as last reviewed in 2013. Policies are referenced including to legislation, best practice guidelines and other evidenced based literature. There is one hard copy of policy manuals available on site and this is sighted. The owner advises the manager (who is not working on the day of audit) is responsible for document control processes. This is confirmed during interview with the AF/MA.

A number of specific template forms are to be used for the recording and reporting of adverse events and includes complaints/compliments/opportunity for improvement form, accident/incident, serious problem form, infection form, challenging behaviour form and medication event form. The number and type of events are analysed, although the information is not always correct. This is raised as an area requiring improvement in 1.2.4.3.

Staff meetings are held monthly. Minutes of the last four meetings held between March and June 2014 are sighted. The minutes includes discussion on a range of operational as well as quality and risk topics. The two caregivers, the accountant, the owner, the registered nurse (RN) and the activities facilitator/managers assistant interviewed confirm they are well informed of quality and risk related issues and improvements required.

The service review meetings, which is where quality and risk is reviewed, occurs three monthly. These meetings are attended by the manager, the activities facilitator/managers assistant, the accountant and the health and safety representative. The minutes of the two meetings held in 2014 includes discussion on occupancy and bed availability, a review of the organisation's goals, a review of incidents/accidents and complaints per category per month. How Eden Rest Home compares with other benchmarked facilities is also discussed. Hazard identification and review, staffing/skill mix, review of policies/procedures, and staff training is also discussed. An annual review of quality and risk programme occurred in February 2014 and this is sighted.

Two of two caregivers interviewed are able to identify the type of events that are required to be reported via the incident reporting process. The two caregivers confirm they are provided with information on the number and types of reported events at the staff meetings.

Internal audits/surveys are being undertaken. Template forms are used for the recording of data. A review of four types of audits selected at random (food services, resident satisfaction, restraint/enabler use and monthly hazards/maintenance audits) occurred during audit Overall there is satisfaction with services provided, and a high level of compliance with the organisation's policies and procedures. Where areas for improvement are identified these are documented in corrective action plans, implemented and monitored for effectiveness.

There is a business risk management plan sighted for 2013 to 2014. This document is reviewed at the service review meetings and this is verified in the minutes sighted. The risk plan includes a range of business, financial, contractual, clinical, resident care and staff related risks. The business risk management register includes information on the likely impact of these events and the likelihood of it happening. Preventative actions to minimise the risk are documented. A monthly facility review to identify maintenance issues and new hazards is being undertaken. The monthly audits for 2014 are sighted and all required maintenance issues or hazards are noted as having been addressed in full.

Resident meetings are held monthly. A review of the meeting minutes for 2014 verify between six and 11 residents attend the meetings. The agenda includes discussion on complaints, activity programme, food, staff training, health and safety and infection prevention and control topics.

The ARRC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

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

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

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Staff interviewed are able to identify the type of events that are required to be reported via the incident reporting process. A review of four residents' files by the second auditor verifies that events that should be reported via the incident reporting process are being reported and the incident reports are placed in the resident's file. The number and type of events each month are being analysed and communicated to staff. The data is not always accurate and this is an area requiring improvement.

The owner is able to identify the type of events that require essential notification or mandatory reporting. Examples provided include serious harm, unexpected death of a resident and outbreaks of infection. The owner advises HealthCert and the DHB were informed at the time the previous manager left employment and the owner took over 'day to day' operational responsibilities.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Two of two caregivers, the RN, the AF/MA, the owner and the accountant interviewed are able to identify the type of events that are required to be reported via the incident reporting process. A review of four residents' files by the second auditor verifies that events that should be reported via the incident reporting process are being reported. Open disclosure is occurring. The completed incident report is placed in the resident's file.

The AF/MA and RN is responsible for investigating and following up all reported events and ensuring short term care plans (STCP) are developed and implemented when required. A review of four incident reports related to two resident falls, a resident refusing medication, and another medication event, verifies that causes are investigated and mitigation strategies implemented and monitored for effectiveness.

A review of the incident data for 2014 and the benchmarking report identifies that there have been two resident falls coded as the resident having had a fracture. This is not correct. One medication error is not included in the monthly totals for January to March 2014. One additional fall noted in the incident benchmarking data is not noted on the incident register in January 2014.

Finding:

Staff are reporting incidents and these are investigated and corrective action plans initiated. The number and type of incidents in the analysis is not always correct. There have been two falls coded as the resident having had a fracture which is not correct. One medication error is not included in the monthly totals for January to March 2014. Another fall noted in the incident benchmarking data is not noted on the incident register in January 2014.

Corrective Action:

Ensure the analysis, reporting and benchmarking of adverse event data is accurate

Timeframe (days): 180 (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:

The good employer policy has a flowchart that details recommended recruitment process including advertising the position, receiving application forms and curriculum vitae, interviewing, reference checks, agreeing on the job description and employment conditions. Induction / training is to occur, staff are to sign the declarations, including confidentiality prior to commencing work. A review of six staff files occurred during audit. A job application, reference checks and employment processes are documented. A police check has been undertaken and the results are on each staff member's file. All six staff have employment contracts present in their file along with a copy of the staff handbook and confidentiality agreement.

Annual performance appraisals have been undertaken for all staff who have been employed at Eden Rest Home for longer than 12 months.

There are processes in place for the monitoring of staff annual practising certificates. The APCs for the RN, three GPs, the pharmacist and the previous clinical manager (who continues to work three hours a month providing staff education and assisting the RN when required) is sighted. A copy of the pharmacy 'licence to operate' is also in the file sighted.

The staff training programme includes orientation/induction of staff and volunteers. The orientation includes the facility, policies and procedures, health and safety, infection prevention and control, incident reporting, complaints, and fire safety/ emergency procedures. Introduction to the residents and caregiver role/responsibilities also occurs. Records verifying the orientation programme has been completed are maintained. At the last audit an area for improvement was identified in relation to ensuring volunteers complete an orientation programme. The AF/MA and owner advise volunteers are not currently providing any services. In the future any volunteer would be required to complete an orientation. The area identified as requiring improvement is not applicable at present.

Ongoing training is planned and topics include those required to meet the requirements of the ARRC contract. The education records for 2013/2014 are sighted. Education is provided monthly. The recent topics have included falls/documentation (January 2014); fire evacuation drill, medication management and wound care (February 2014); the aging process/skin tears and medication competencies (March 2014); cultural safety, sexuality/intimacy and observation/monitoring (April 2014); diabetes and urinary tract infections (May 2014) and hand hygiene and documentation (June 2014). Between five and ten staff have attended each in-service.

ARRC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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 management policy' specifies the staffing required to meet the ARRC contract requirements. This includes a minimum of one staff member on duty and one on call. The RN confirms being available on call when not on site. The RN comes on site at least two days a week and more frequently if required. The time on site is reported to vary and is based on residents' care needs. The previous clinical manager (who remains employed in a very different role) now predominantly provides staff education for three hours a month. This RN is also noted on the roster to also provide some RN on call services.

The staff planning tool details the recommended number of RN and caregiver hours based on the current occupancy. This tool is sighted to be in use at audit, and does not include the hours the two owners are on site.

The roster on site for the week 14 to 20 July verifies there is one caregiver rostered on each duty and a caregiver is on call each day. The RN and the owner are also on call. There is a cleaner who works three hours a day weekdays and two hours a day on the weekend. There are designated hours for the cook.

The accountant has rostered hours on site. The manager works predominantly Tuesdays and Thursdays. The activities facilitator/managers assistant works weekdays between 9 am and 5.30 pm four days and 2pm to 5.30 pm on a Thursday. The owner advises being on site during the morning and early afternoon seven days a week.

The owner accompanies residents to off-site appointments. The owner's spouse undertakes maintenance, renovation and gardening duties.

Five of five residents interviewed with the assistance of an interpreter confirm they are receiving care in a timely manner from staff and are very satisfied.

The new caregiver (who works three night shifts a week) has not yet completed first aid training. This is raised as an area requiring improvement in 1.4.7.1. The owner advises it has been difficult recruiting a Cantonese speaking caregiver for the night shifts.

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 four of four residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Entries into the progress notes are made each shift which records the staff member's name and designation. The current progress notes are in all in one integrated file.

Evidence is seen in resident's files of required data being obtained and kept confidential. This is easily identifiable and accessible for staff and other health care providers.

Files that are not current are stored in a locked room on the same property at the facility. All health care providers use the integrated file in the nurses' station.

The previous area for improvement relating to residents' files not being kept in a secure cupboard has been addressed.

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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:

Prior to entry, the resident must be assessed by the Needs Assessment and Service Co-ordination (NASC) agency in the area to ensure they require rest home level care. Access and entry criteria are documented and communicated to residents and their family/whanau by local doctors, referral agencies, the DHB hospital and local community groups.

If a telephone enquiry is received from someone who has not been assessed, they are advised to contact their GP or the local NASC agency. Entry criteria is verbally explained to anyone making an enquiry and information packs are sent out or given to prospective residents when they call in. Prospective residents/family/whanau are encouraged to tour the facility with the RN or owner and take the time for discussion.

The previous area for improvement relating to ensuring all residents have a NASC prior to admission has been addressed.

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: FA

Evidence:

Service delivery documentation is overseen by the RN at Eden Rest Home. Documentation is part of the audit process and reviewed at regular intervals to ensure documentation is completed within required timeframes. In the four files reviewed there is evidence of initial assessments and care plans being completed within required timeframes. The clinical risk tools used includes falls, pressure area, incontinence, pain and challenging behaviour. The rest home has not commenced using interRAI computer programme for assessments but the RN is in the process of completing the training. The long term care plan template is personalised, reviewed and amended within required timeframes.

The RN reports there is a process for annual multidisciplinary resident reviews or earlier review if required. There are three monthly reviews with the GP and clinical staff. Family are notified of any changes. There is evidence in the four files reviewed that family/whanau are involved in all areas of care management. The rest home has the services of a GP who visits twice weekly or at other times if required. The GP covers on call cover 24 hours a day, seven days a week (24/7), for all residents and has a relief GP when he is not available. He has been with the facilities for four years and was available by phone for interview during the audit.

The RN reports regular contact is undertaken with the community gerontology nurses who will visit as required. Referrals are made to the dietitian for any unexplained weight loss.

The five residents interviewed using the interpreter are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed (one RN two caregivers one cook and one activities coordinator) report that they are kept up to date with all clinical changes.

Tracer Methodology Rest Home:

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: FA

Evidence:

Evidence:

In the four residents' files reviewed there is evidence of the needs of residents being assessed in line with their desired outcomes. This includes remaining as independent as possible and being included in all care decisions. The five residents report on interview that they are involved in their care and feel that they are treated as an individual. There are no relatives available for interview during the audit as many of the residents have no family contacts.

The five staff report on interview that they know the residents individually, as it is a small facility, and they ensure they work within the residents' care plans, which are based on the residents' assessed needs.

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:

Eden Rest Home facility has an activities coordinator who also acts as the assistant manager. Delegated staff members each undertake an area of the programme when required. This includes a tai chi exercise programme in the morning and mah-jong in the afternoon. All residents on the day of the audit are assessed to be of Chinese origin and the activities programme reflects this. The morning Tai Chi and afternoon mah-jong activities are a popular pastime for residents of this culture.

The documentation for activities is up to date and reviewed as required. The five residents report they are happy with the activities provided and staff report they are encouraged to participate in the programme and enjoy the activity involvement.

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:

Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in the four files reviewed. Progress notes are signed each duty by caregivers and weekly by the RN. Evidence is seen of the family/whanau involvement in the care reviews. In all four files reviewed evidence is seen of documentation if an event occurs that is different from expected. This includes evidence of contacting family, when available. The five residents interviewed report that they are given the opportunity to be involved in all aspects of care and reviews.

The five clinical staff interviewed understand documentation requirements and report they are informed at changeover of any care changes to residents.

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:

Eden Rest Home uses the blister pack whereby medicines are delivered weekly except for as required (PRN) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the RN and evidence is seen of the signing sheet. There are no controlled drugs on the premises. There is evidence in all eight medication charts that they are reviewed by the GP three monthly or as required. All medicine charts are signed in ink to meet legislative requirements.

Standing orders are not used at this facility.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reports that the GP works with the pharmacy but he is responsible for all medicines administered to his residents.

The caregivers are responsible for all medication rounds and evidence is sighted of medication competency certificates. The lunchtime medication round was observed and complies with regulation requirements.

There is one resident who self-medicates his inhalers only. Evidence is seen of competency to do so and sign off by the GP.

The previous areas for improvement relating to a sheet for specimen signatures of staff administering medication being available and the record of residents who self-medicate has been addressed.

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:

Eden Rest Home uses a seasonal menu which is reviewed by a dietitian with in timeframes. An individual dietary assessment is completed on admission which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP and notifying the kitchen of extra dietary requirements. The service is managed by two cooks over seven days. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. Evidence is seen of attendance at annual update education on infection control and first aid and both cooks have completed the safe food handling certificate on line. The cook reports on interview that she is supported by management with food supplies and understands the individual requirements of the residents.

The menu is specifically designed with the Chinese culture of the residents taken into consideration and evidence is seen on the menu of Chinese meals.

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.3.13.5 (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.

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

Finding:

Corrective Action:

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

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: PA Low

Evidence:

There is a current building warrant of fitness. Electrical test and tagging and performance monitoring of clinical equipment is overdue. These are areas requiring improvement.

Eden Rest home has applied for approval for another resident bedroom to be certified. This makes a total of 17 beds. This new bedroom amalgamated what was previous the nursing station and the public toilet. Whilst there is a call bell present and window of natural proportions; there is a toilet present in the corner of the bedroom that is open/exposed. The toilet is directly in front of the bedroom door from the corridor and without any privacy features. This is an area requiring improvement.

There are suitable outdoor areas for residents and family members to use.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The building has a current building warrant of fitness which is displayed on the wall. Electrical appliances checked are overdue electrical test and tagging. The labels note a two yearly testing requirement which was due earlier in July 2014. The clinical equipment sighted is overdue performance monitoring checks. These checks were due in April 2014. These are areas requiring improvement. The AF/MA, owner and RN interviewed were unaware of when these checks were next required to be completed/due.

Finding:

The test and tagging of electrical appliances was due for review on 7 July 2014. This was last completed in 2012. The annual performance monitoring of clinical equipment is overdue. It was last completed in April 2013.

Corrective Action:

Ensure electrical equipment in use has current test and tag labels. Ensure annual performance monitoring is occurring of clinical equipment.

Timeframe (days): 180 (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: PA Low

Evidence:

Eden Rest Home has applied for approval for another resident bedroom to be certified. This room amalgamated what was previous the nursing station and a public toilet. There is a call bell present and window. The flooring is linoleum. There is a toilet present in the corner of the bedroom that is open/exposed. The toilet is directly in front of the bedroom door (from the corridor). The owner and AF/MA interviewed advise the resident currently occupying this room and the residents family are happy with this arrangement.

There are hand rails present on one side of the walls in the corridor. The floor is even and floor furnishings intact and appropriate to rest home level care residents.

There are two external areas where residents can rest. One is undercover so accessible in all weather. There is a designated smoking should residents want to smoke. ARRC contract requirements are met.

Finding:

Eden Rest Home has applied for approval for another resident bedroom to be certified. This room amalgamated what was previous the nursing station and a public toilet. Whilst there is a call bell present and window of natural proportions; there is also a toilet present in the corner of the bedroom that is open/exposed. The toilet is directly in front of the bedroom door from the corridor.

Corrective Action:

Ensure the toilet is suitably contained in the additional room for which approval has been sought.

Timeframe (days): 180 (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.)

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: PA Moderate

Evidence:

The emergency planning, pandemic planning and security systems policy provides guidance for staff in response to a range of emergencies including fire, different types of natural disasters, loss of water or other essential utilities, management of malicious calls, intruders and bomb threats. The policy also provides guidance for staff on the use of personal protective equipment (PPE) and what to do if an outbreak of infection is suspected. This document has been localised to reflect the need of Eden Rest Home. A flip chart which details the response to emergency events sighted on the walls in various staff areas of the rest home. The equipment required to be held for use in emergencies is detailed. There are a number of containers containing, torches, PPE, kitchen supplies, rubbish bags, chemicals and toiletries. There is sufficient drinking water available. A supply of spare blankets and duvets is also present.

The facility has a fire evacuation plan which has been approved by the NZ Fire service in 2008. A most recent fire evacuation drill was undertaken on the 8 March 2014. The owner advises the addition of the new bedroom had not required a change to the fire evacuation plan. The resident register and fire evacuation list/register contains the names of two residents discharged 16 days prior to audit. The two resident names remain on the bedroom doors. This is an area requiring improvement.

A new caregiver (employed to work three nights a week) does not have a current first aid certificate and is an area requiring improvement. A staff member with a current first aid certificate is rostered on all other shifts.

There are call bells present in resident rooms and toilets. Two tested at audit alarmed through to the central monitoring station. This includes the call bell from the new bedroom. The AF/MA advises checking the call bell functioning is a component of the monthly internal audit programme and these audits are sighted.

Security cameras monitor the main corridors and lounge areas. The cameras are monitored on a screen in the manager's office and this is 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: PA Moderate

Evidence:

The facility has a fire evacuation plan which has been approved by the NZ Fire service. A letter is sighted dated 5 August 2008. A fire evacuation drill was undertaken on the 8 March 2014. Ten staff are documented as having attended this fire evacuation drill which was facilitated by an external consultant. The owner advises the addition of the new bedroom has not required a change to the fire evacuation plan.

It is observed during audit that the resident occupancy board and the fire evacuation register includes the names of two residents who were transferred out from this facility on the 29 June 2014. In addition these residents' names remain on signs of the bedroom door despite the rooms not being occupied. The inclusion of discharged residents in the current occupancy, fire evacuation list and as names on bedroom doors may pose a risk in the event of an emergency and is an area requiring improvement.

A new caregiver employed to work three nights a week does not have a current first aid certificate. This is an area requiring improvement. A staff member with a current first aid certificate is rostered on all other shifts as verified via a review of the roster and review of staff and the owner's first aid certificates.

Finding:

At audit the resident board and the fire evacuation list contains the names of two residents discharged on the 29 June 2014 (16 days prior to this audit). The resident's names are also still noted on the bedroom doors.

A new staff member has been employed to work night shift three days a week. This staff member does not have a current first aid certificate and is in on shift as a sole employee.

Corrective Action:

Ensure the resident list and fire evacuation list is kept current. Ensure a staff member with a current first aid certificate is on duty at all times.

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

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation 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.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when 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 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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:

Eden Rest Home has a no restraint policy. There are documented guidelines on the use of enablers. Definitions in the policy document are congruent with the requirements of the Health and Disability Services Standards. There are also guidelines on the management of challenging behaviours. Staff interviewed (two caregivers and the AF/MA) confirm they are provided with training on the use of enablers.

Five residents have an enabler (bed loop) attached to their bed to help them get in and out of bed and these are sighted. Assessments and consents for the use of the enablers are sighted in all five residents' files. These consents have all been signed by the resident, the RN and the general practitioner. All five residents using enablers are documented in the restraint/enabler register and this is sighted. There is no evidence of restraint use during the audit.

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:

Surveillance results are used to identify infections or events and are appropriate for the size and level of rest home service.

Analysis includes identification of infections that are affecting one or multiple residents, what organism was identified and the possible causes. If infection rates are higher than expected a corrective action is implemented for follow up. The infection data form has actions, interventions and evaluation of the actions for each individual resident with an infection. The infection data is evaluated and trends analysed.

If the infection analysis identifies specific infections, education sessions will be undertaken with staff (e.g., urinary tract infections). The infection prevention and control coordinators report that the staff would be encouraged to increase fluid intake.

All surveillance data is reported at staff meetings and evidence of this is seen in the minutes. The five clinical staff interviewed report they receive annual infection control education and understand the need to report 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.)*