# Castlewood Nursing Home Limited

## Current Status: 8 July 2014

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

## General overview

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract.

Castlewood rest home provides care for up to 24 residents for rest home level of care. There has been an alteration to the building since the last certification audit increasing bed numbers from 21 to 24. There were 24 rest home residents residing at the facility on the audit day.

One area identified requiring improvement at the last certification audit relating to weekly stock count of controlled drugs has been addressed.

There are new areas identified at this surveillance audit that require improvement around admission agreements, complaints management, policy reviews, corrective action plans, resident and /or family input into care planning, medication management and staff medication competencies.

## Audit Summary as at 8 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 8 July 2014

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 8 July 2014

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

### Continuum of Service Delivery as at 8 July 2014

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

### Safe and Appropriate Environment as at 8 July 2014

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

### Restraint Minimisation and Safe Practice as at 8 July 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 8 July 2014

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Castlewood Nursing Home Limited |
| **Certificate name:** | Castlewood Nursing Home Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Castlewood Nursing Home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 8 July 2014 | **End date:** | 9 July 2014 |

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| **Proposed changes to current services (if any):** |
| Increase in number of beds from 21 to 24 |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 24 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 7 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 17 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXXXXX, Managing Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 22 July 2014

## **Executive Summary of Audit**

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| **General Overview** |
| This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract.  Castlewood rest home provides care for up to 24 residents for rest home level of care. There has been an alteration to the building since the last certification audit increasing bed numbers from 21 to 24. There were 24 rest home residents residing at the facility on audit day.  One area identified requiring improvement at the last certification audit relating to weekly stock count of controlled drugs has been addressed.  There are new areas identified at this surveillance audit that require improvement around admission agreements, complaints management, policy reviews, corrective action plans, resident and /or family input into care planning, medication management and staff medication competencies. |

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| **Outcome 1.1: Consumer Rights** |
| An open disclosure policy is documented and implemented. Interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed in the facility. Staff, residents and family interviewed demonstrate an understanding of the complaints process. A complaints register is maintained. There are areas requiring improvement around admission agreements and the complaint processes. |

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| **Outcome 1.2: Organisational Management** |
| Castlewood rest home has established systems in place which define the scope, direction and goals of the facility, and the monitoring and reporting processes against these systems. Monitoring and communication of quality improvement data occurs via the management and staff meetings. Internal audits are conducted. Castlewood rest home is managed by a manager, who is supported by a registered nurse and care givers. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is evidence in the residents’ files reviewed of adverse event reporting. Residents files reviewed also provide evidence of communication with families following adverse events or change in a resident’s condition.  The human resource management system provides for the implementation of processes both at the start of employment and on an ongoing basis in relation to education and training. There are regular in-service education and training opportunities provided for staff. A sampling of staff records evidences human resource processes are followed.  There is a documented rationale for determining staff levels and staff skill mixes. A registered nurse employed for 25 hours a week. There are areas requiring improvement around policy review and corrective action plans. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Residents receive services meeting their assessed needs, confirmed during four residents and four family interviews.  Residents receive adequate and appropriate services in order to meet their assessed and desired needs. Care plans record interventions based on the assessed needs, desired outcomes or goals of the residents. However there is a requirement for improvement relating to evidence of resident and or family input into care planning. The resident’s files reviewed have care plans reviewed at six monthly intervals. Evaluations are completed when the needs of the residents change. The activities programme is written daily on a white board in the lounge. The service keeps records of attendance and activities focus on  developing and maintaining skills and strengthening current abilities of residents.  Medicines are stored in a locked medicines cupboard at the nurses’ station and kept free from heat, moisture, and light and stored in original dispensed packs. The controlled drug register is maintained and staff complete weekly stock takes. Controlled drugs are stored in a secure, locked safe inside a cupboard in the nurses’ station. The lunch time medication round was observed. There are requirements for improvement relating to the RN having to use safe and appropriate procedures for administration of medicine, documentation of medicines and medicines management competencies to include written and practical evaluations. The previous requirement for improvement relating to medicines management is fully implemented.  Policies and procedures relating to food services are appropriate to the service setting. The menu is developed by a dietitian.  Resident's individual dietary needs are identified, documented and reviewed as part of the nutritional assessment on admission of the resident. The cook is informed when resident's dietary needs change. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There has been an increase from 21 to 24 residents’ rooms. There is current building warrant of fitness. NZFS evacuation scheme approval dated 27 March 2001, sighted. Fire Safety Advisory Services fire design report and evidence there is no change to staff procedures as laid out in the original evacuation scheme which has been approved by the NZ Fire Service was sighted.  Review of documentation, visual observation and interviews with residents, family and staff provide evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has no residents utilising restraint and no residents using enablers. There are systems in place to ensure the use of restraint is actively minimized. Staff interviews and records evidence education and training relating to restraint minimisation and safe practice. Restraint forms a part of the service’s risk and quality management system. The service’s definitions of restraint and enabler are congruent with the definition in NZS 8134.0. The restraint register is current. |

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| **Outcome 3: Infection Prevention and Control** |
| The service completes monthly surveillance of the infections according to the number and type of infection. Specimens are sent for laboratory testing in order to establish sensitivities for prescribing of antibiotics. The infection control policy is reviewed bi-annually. Surveillance data is communicated to the staff and the owner of the rest home. The service completes six monthly infection control audits. Data is expressed in graphs and pie charts. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 12 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 5 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 55 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The admission agreement does not contain all required information as per the DHB contract. | Provide evidence all required information is recorded in the resident’s admission agreement, as per the DHB contract. | 180 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The complaint processes are not being followed as per Right 10 of the Code. | Provide evidence of the complaints process complying with Right 10 of the Code. | 180 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.3 | 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. | PA Low | Policies require review, obsolete policies require removal from current policies and some policies require to be recorded as per DHB contract. | Provide evidence policies are reviewed regularly by an appropriate person, reference current legislation and guides and obsolete documents are filed. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective action plans and evidence of implementation is not recorded for some audit and satisfaction surveys. | Provide evidence corrective action plans are developed and implemented where this is required. | 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 | None of the five files reviewed have written evidence that the resident and or the family contributed to the care plan. One resident whose file was assessed did not evidence input from the resident or the family into the long term care plan. | All care plans to show evidence of resident and or family participation and input to care planning. | 365 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | i) GPs do not always sign and date all entries on the medicines charts. ii) The RN was observed to not administer medicines according to policy. | i) GPs to sign and date all entries on the medicines charts. ii) The RN to administer medicines in a safe and appropriate manner. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Competency testing for medicines management, including administration of insulin, does not include a written and practical evaluation. | Competency testing for medicines management, including administration of insulin, to include both a written and practical evaluation. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are policies and procedures in place to support the open disclosure practice in the facility. Staff education on open disclosure was last provided in October 2013, evidenced in four of four staff files reviewed and recorded on staff education planner. Incident forms and residents’ progress notes evidence family are informed of adverse events or when resident’s condition alters. Four of four residents and four of four family interviewed confirm that staff and management communicate well with them. Residents meetings occur every two months, sighted minutes of meetings for 2013 and 2014. The manager advises there are no residents requiring interpreter services at time of audit. There is an area requiring improvement around content of the admission agreement. The district health board contract requirements are not fully 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Open disclosure policy is recorded. Residents and family interviews confirm they are informed of adverse events in timely manner. The admission agreement does not contain all required information. |
| **Finding:** |
| The admission agreement does not contain all required information as per the DHB contract. |
| **Corrective Action:** |
| Provide evidence all required information is recorded in the resident’s admission agreement, as per the DHB contract. |
| **Timeframe (days):** 180 *(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.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The complaints policy and procedure are congruent with Right 10 of the Code of Rights. The complaints register is monitored by the manager. Complaints registers for 2013 and 2014 are reviewed. There are two complaints for 2013 and no complaints in 2014. The complaints forms and information is located in the lounge.  Complaints audit was last conducted in July 2013 with 100% compliance. Staff education on complaints management was conducted in May 2013, sighted in staff files reviewed and on the staff in-service planner for 2013. Staff interviews confirm they are aware of the complaints process.  Four of four residents and four of four family members interviewed are aware of the complaints processes. Health and Disability Commissioner (HDC) brochures on Code of Rights are displayed. The Nationwide Advocacy Service and the HDC contact details are also available.   The manager states there have not been any complaints since the last certification audit, referred to the Health and Disability Commission, police, coroner, accident corporation or Ministry of Health. There is an area requiring improvement around the complaints processes. The district health board contract requirements are not fully 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are two complaints on the complaints register for 2013. No complaints are recorded for 2014. Complaint (October 2013) was reviewed and evidences a written complaint was received by the facility relating to respite resident’s care. Reply letter to the complainant does not evidence a date this was sent, however the register date is recorded as within the five day period, there is no close out date or acknowledgement of acceptance of the investigation and close out of the complaint. |
| **Finding:** |
| The complaint processes are not being followed as per Right 10 of the Code. |
| **Corrective Action:** |
| Provide evidence of the complaints process complying with Right 10 of the Code. |
| **Timeframe (days):** 180 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Castlewood rest home has systems in place which record the scope, direction and goals of the service. Monthly management meetings include quality and risk management issues, internal audit outcomes, and clinical indicators, sighted. Castlewood rest home philosophy is displayed at entrance to the facility. Castlewood rest home business plan for 2014 is sighted.  The owner is a registered nurse, however, they does not have a current practicing certificate. The owner is not available for interview. The manager is employed full time and has been the manager at this facility for 15 years. They have completed the national certificate in rest home care. The manager has experience relevant to both management and the health and personal care of older people and is able to show evidence of maintaining at least eight hours annually of professional development activities relating to managing a rest home. The registered nurse (RN) is employed for 25 hours a week, has a current practicing certificate and has been in this position for one month.  Castlewood rest home has contracts with the Otago District Heath Board (DHB) for rest home services and aged related residential respite care. The district health board contract requirements are fully 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are quality and risk management systems in place, sighted. There is evidence the quality improvement data is collected, collated, evaluated, and analysed to identify trends, however corrective action plans where required are not always developed and implemented and this requires an improvement.  An internal audit schedule and completed audits for 2014 are reviewed. Quality and risk management data and quality improvement data is reported at the facility’s meetings. Management and staff meeting are held monthly and there is evidence of quality activities discussed. Sighted resident meeting minutes for March, May and July 2014.   Residents’ satisfaction survey was conducted in May 2014 and this is awaiting collation. The 2013 resident satisfaction survey results are reviewed and evidence return rate of 67 % with some areas identified requiring improvement, however there is no evidence of a corrective action plans and implementation and this requires an improvement. Family satisfaction survey was last conducted in 2014 and summary of the survey evidences the return rate is at 41% and the results record some suggestion for improvement, however there is no evidence of the results being communicated to respondents.  There are areas requiring improvement around policy review and corrective action plans. The district health board contract requirements are not fully 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policies are reviewed by the manager and not all policies and procedures are current. Some policies reference old legislation and guides. There are obsolete polices in the policy folder. There is no evidence of a document control policy and wound management policy. |
| **Finding:** |
| Policies require review, obsolete policies require removal from current policies and some policies require to be recorded as per DHB contract. |
| **Corrective Action:** |
| Provide evidence policies are reviewed regularly by an appropriate person, reference current legislation and guides and obsolete documents are filed. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.4 (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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Audits are conducted and results of audits are discussed as meetings. Sighted audits for 2014. There are some audits and satisfaction survey that require corrective actions, however there is no recorded evidence of a corrective action plan or documentation of the implementation of the corrective action. |
| **Finding:** |
| Corrective action plans and evidence of implementation is not recorded for some audit and satisfaction surveys. |
| **Corrective Action:** |
| Provide evidence corrective action plans are developed and implemented where this is required. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an adverse event reporting system in place. All accident/incidents are recorded and reported on. January to June 2014 accident /incident summary sighted recording 40 incidents for the six month period.  Communication with families following adverse events, or any change in resident’s condition is evidenced in the residents’ files reviewed. Staff interviews confirm awareness of the adverse event process.  Staff are made aware of their essential notification responsibilities through their job descriptions, policies and procedures and professional codes of conduct.  The district health board contract requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures in relation to human resource management. There is a planned and documented staff in-service education plan, sighted 2014 in-service education plan and staff files recording attendance. Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff interviews confirm orientation / induction is provided for new staff.   Annual practising certificates are current for all staff who require them to practice. Four of four staff files evidence human resources systems are adhered to. The district health board 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented staffing rationale policies for determining staffing levels and skill mixes.  Staff interviews confirm staff are able to get through their work.  Residents interviewed state the care they receive is appropriate to their needs. Roster sighted for June and July 2014 and evidence the manager is employed full time, Monday to Friday. There is a registered nurse employed Monday to Friday, 25 hours a week. On call is shared by the manager and the registered nurse. Staff interviews confirm awareness of the on call processes. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents receive services meeting their assessed needs, confirmed during four residents and four family interviews. However a record of one resident shows no written evidence of the resident and or the family contributing to the care plan. Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and / or experienced staff members. The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach.   Tracer methodology in the Rest Home:   *XXXXXX This information has been deleted as it is specific to the health care of a resident*  The district health board contract requirements are not fully 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The initial assessment is also used as the initial care plan. All reviewed resident files evidence initial care plans completed on admission to the service. The residents have long term care plans developed within three weeks from admission and reviewed at six monthly intervals or when the resident’s condition changes. The medical reviews by the GP are not consistently completed at three monthly intervals (Refer to 1.3.12.1). Resident and family interviews confirm having opportunity to participate in care planning. |
| **Finding:** |
| None of the five files reviewed have written evidence that the resident and or the family contributed to the care plan. The resident whose file was assessed did not evidence input from the resident or the family into the long term care plan. |
| **Corrective Action:** |
| All care plans to show evidence of resident and or family participation and input to care planning. |
| **Timeframe (days):** 365 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents receive adequate and appropriate services in order to meet their assessed and desired needs. Five resident files sampled evidence the care plans record interventions based on the assessed needs, desired outcomes or goals of the residents.   The GP documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of their Service Agreement. Five residents interviewed confirm their current care and treatment they are receiving meets their needs. The district health board contract 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The diversional therapist (DT) plans and implements the activities programme for the service. The service has one DT that works 30 hours, five days per week, Monday to Friday. The diversional therapist confirms having access to diversional therapy guidance in Central Otago and having completed the qualification in 2002.  The activities programme is written daily on a white board in the lounge. The daily programme consist of several activities including cooking and baking, sighted historical attendance records. Resident interviews confirm they are enjoying activities.   Five resident files sampled demonstrate the individual activities service plans are current. The residents' recreational assessments were sighted in all five residents files sampled. Residents interviewed confirm their past activities are considered during assessment and activities are voluntary. The district health board contract 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The resident’s files reviewed have care plans reviewed at six monthly intervals. Evaluations are completed when the needs of the residents change, confirmed during interview with the RN and sighted in the long term care plan of residents.  The district health board contract requirements are 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Visual inspection of the medication area in the facility evidences appropriate and secure medicine management processes. Medicines are stored in a locked medicines cupboard at the nurses’ station and kept free from heat, moisture, and light and stored in original dispensed packs.   The controlled drug register is maintained and staff complete weekly stock takes (drug checks) which are recorded in the controlled drug register. Controlled drugs are stored in a secure, locked safe inside a cupboard in the nurses’ station. The controlled drug register is maintained and six monthly physical stock takes of controlled drugs by pharmacist are also conducted.  The lunch time medication round is observed. There are requirements for improvement relating to the RN having to use safe and appropriate procedures for administration of medicines, all entries to the medicines charts to be signed and dated and medicines management competencies to include written and practical evaluations.  Medicines management training occurred within the previous 12 months. The service has no residents who self-administer medicines. The district health board contract requirements are not fully 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Entries to the medicines charts are not consistently signed by the general practitioner and the registered nurse was observed to administer medicines from the palm of her hand during the medicines round at lunch time. |
| **Finding:** |
| i) GPs do not always sign and date all entries on the medicines charts. ii) The RN was observed to not administer medicines according to policy. |
| **Corrective Action:** |
| i) GPs to sign and date all entries on the medicines charts. ii) The RN to administer medicines in a safe and appropriate manner. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.3 (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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medicines management competency testing is currently a verbal test and is completed by the registered nurse. Caregivers also administer insulin; however the service has not implemented a competency programme for insulin administration. |
| **Finding:** |
| Competency testing for medicines management, including administration of insulin, does not include a written and practical evaluation. |
| **Corrective Action:** |
| Competency testing for medicines management, including administration of insulin, to include both a written and practical evaluation. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures relating to food services are appropriate to the service setting, providing seasonal (summer and winter) menus that rotate every four weeks. The menu is developed by a dietitian and last reviewed in April / May 2014, confirmed by the cook during interview.   Resident's individual dietary needs are identified, documented and reviewed as part of the nutritional assessment on admission of the resident. The cook is informed when resident's dietary needs change, confirmed during interview. Additional food and snacks are available for residents in the form of fruit, biscuits and sandwiches.  Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. Four residents and four relatives interviewed are satisfied with the food service. The fridge and freezer temperature are monitored weekly, sighted records.  The kitchen staff completed food safety training, the main cook completed food safety training as part of the Health and Safety certification course in 2002 and the second cook is currently completing the Health and Safety certification course, including safe food handling, sighted trainings programme and records.  The district health board contract requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an increase from 21 to 24 residents’ rooms by adding onto the existing building. Visual inspection evidences additional bedrooms with ensuites between. All bedrooms are large enough to enable residents, staff and equipment to be in the rooms during service provision.  Review of documentation, visual observation and interviews with residents, family and staff provide evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.   The manager confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. There is a current Building Warrant of Fitness that expires 30 May 2015.  A visual inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to an adequate standard.  Safety rails are secure and are appropriately located, equipment does not clutter passageways, floor surfaces/coverings are appropriate to the resident group and maintained in good order. The external areas are appropriate to the resident group and setting.  Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs and this was observed during the on-site audit.   Audit of management of waste and hazardous substances was conducted in January 2014 and results discussed at management meeting in February 2014 and staff meeting in January 2104. Audit of the environment was conducted in August 2013 with 100% compliance and results of this audit were communicated to staff in October 2013 at staff meeting and discussed at management meeting in October 2013. Hot water temperatures are monitored three monthly. The district health board contract requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place for essential, emergency and security services.  There is at least one designated staff member on each shift with appropriate first aid training, sighted current first aid training in staff files reviewed. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records evidence this. There is evidence that information in relation to emergency and security situations is readily available and emergency equipment is accessible   There is a call bell system in place and call bells are accessible confirmed at resident interviews.   Sighted evacuation and drill and staff training conducted by fire safety advisory services in April 2014. Audit of emergency supplies was conducted in April 2014 with 100% compliance. NZ Fire Service evacuation scheme approval dated 27 March 2001, sighted. Fire Safety Advisory Services fire design report to the council records there is no change to staff procedures as laid out in the original evacuation scheme, which has been approved by the NZ Fire Service is sighted.  Heating at the facility is by wall heaters in residents’ bedrooms, night store heaters in hall ways and heat pumps in the lounge. In case of power failure gas heaters are available and there are gas cooking hobs in kitchen. Hot water is heated by gas. BBQ and emergency drinking water is available. The district health board contract requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint register show that there are no residents using restraint and or enablers in the facility. Four resident and four family interviews confirm that there is no use of restraints throughout the facility. There are no enablers being used in the facility. The service provides on-going training to staff, in the management of challenging behaviour. The RN and health care assistants confirm they are familiar with managing challenging behaviour. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Interview with the infection control coordinator (ICC) confirms surveillance is carried out in accordance with the service’s infection control policies. The monthly infection control reports for January, February, March and April 2014 are reviewed.   The reports include the total number of infections for the time period, the type of infections and organisms, the number of resolved infections and the reports are expressed as a percentage per 100 residents per month. The surveillance reports are completed and given to the manager who reports to staff and to the owners of the service.  The service completes six monthly infection control audits, sighted which include a general summary, statistics, key issues, actions to be taken and implemented with timeframes and key people identified.  The ICC compiles comparative graphs and the service participates in benchmarking within the region. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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.

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