# Golden Age Health Care Limited

## Current Status: 19 August 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

Abbey Heights Rest Home is one of three aged care facilities that are privately owned by Golden Age Healthcare Limited. The facility offers rest home level care for up to 24 residents. On the day of audit 21 beds are occupied.

The day-to-day operation of the facility is undertaken by the manager who is suitably qualified and he is supported by the owner/directors and a registered nurse who works Monday to Friday and is on call as required.

Two areas identified for improvement in the previous audit have been fully attained. Two new areas for improvement are identified and relate to medication management.

## Audit Summary as at 19 August 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 19 August 2014

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

### Organisational Management as at 19 August 2014

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

### Continuum of Service Delivery as at 19 August 2014

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

### Safe and Appropriate Environment as at 19 August 2014

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

### Restraint Minimisation and Safe Practice as at 19 August 2014

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

### Infection Prevention and Control as at 19 August 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## Introduction

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

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

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

## Audit Report

|  |  |
| --- | --- |
| **Legal entity name:** | Golden Age Health Care Limited |
| **Certificate name:** | Golden Age Health Care Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Abbey Heights Rest Home |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 19 August 2014 | **End date:** | 19 August 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 21 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 7 | **Hours off site** | 5 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 7 | **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** |  |  |  | **Hours** |  |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 14 | Total audit hours off site | 9 | Total audit hours | 23 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 5 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 3 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 6 | Total number of staff (headcount) | 11 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed |  |

## Declaration

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

I confirm that:

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

Dated Wednesday, 3 September 2014

## Executive Summary of Audit

**General Overview**

Abbey Heights Rest Home is one of three aged care facilities that are privately owned by Golden Age Healthcare Limited. The facility offers rest home level care for up to 24 residents. On the day of audit 21 beds are occupied.

The day-to-day operation of the facility is undertaken by the manager who is suitably qualified and he is supported by the owner/directors and a registered nurse who works Monday to Friday and is on call as required.

Two areas identified for improvement in the previous audit have been fully attained. Two new areas for improvement are identified and relate to medication management. The requirements of the provider’s agreement with the district health boards are met.

**Outcome 1.1: Consumer Rights**

The service adheres to the principles of open disclosure and notifies residents and their families where necessary and appropriate.

The service implements a fair and easily accessible complaints management system which is understood by residents and family/whanau.

**Outcome 1.2: Organisational Management**

The owner/directors and facility manager ensure that services are planned and coordinated to meet consumers' needs as identified in the organisations business plan which is reviewed annually. Planning processes are evaluated quarterly to measure achievement outcomes.

The service has a quality and risk management system which is shared, understood and implemented by staff. Corrective action planning is used to improve service delivery where appropriate.

Adverse events are documented and identify that family/whanau are notified as appropriate and information is used as opportunity for improvements.

Human resources management processes meet legislative requirements. Staff report they are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education. The service implements staffing levels and skill mixes that meet contractual requirements.

The previous area for improvement to ensure staff record their designation in the daily care log is now addressed.

**Outcome 1.3: Continuum of Service Delivery**

The provision of services is delivered by suitably qualified and experienced staff who are able to communicate effectively with the mostly Chinese residents. The registered nurse conducts the initial assessment and initial care plan on the resident’s admission to the service. The care plans reflect the interventions required to meet the residents’ needs. The provision of care is appropriate for residents at the rest home level of care.

The activities are planned to meet the needs and strengths of the residents, with a focus on culturally appropriate activities to the current group of residents.

The menu is reviewed by a dietitian as suitable for the older person living in a care facility and is reflective of culturally appropriate meals. An area requiring improvement for the storage of opened food items is addressed at the time of audit.

Safe medicine administration is observed on the day of audit. There are areas requiring improvement to ensure staff who are responsible for medicine management have a current assessment to ensure they are competent to perform the role and that there is ongoing implementation and monitoring of the storage and disposal of medicines.

**Outcome 1.4: Safe and Appropriate Environment**

Abbey Heights Rest Home has a valid building warrant of fitness. There have been no changes to the facility footprint since the previous audit.

The area requiring improvement in the previous audit related to bathroom facilities has been fully addressed by the service and is now fully attained.

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

There are currently no restraints or enablers in use. Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. Staff undertake annual education related to restraint minimisation and can verbalise their knowledge and understanding of restraint management should it ever be required.

**Outcome 3: Infection Prevention and Control**

The service has an appropriate system for the surveillance of infections that reflects the size and scope of the service. The surveillance data is externally benchmarked. Where the infection rates are higher than expected the service implements a risk management plan to address any shortfalls identified.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 17 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| 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 Low | There was expired medicine in the medication fridge, which was removed at the time of audit.  | Ensure there is ongoing monitoring and implementation of safe medicine management practices in relation to the storage and disposal of medicines. | 180 |
| 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 Low | The RN does not have a documented competency for medicine management.  | Ensure staff responsible for medicine management are assessed as competent to perform the function for each stage they manage. | 180 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has procedures in place to ensure residents, and family where appropriate, have a right to full and frank information and open disclosure from service providers. The two of two family members interviewed confirm they are kept informed of the resident's status, including any events adversely affecting the resident. A family contact sheet is held in each resident's file. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in three of three residents' files). Both the family members interviewed feel that the communication is a strength of the service. One family member commented that when their family member had an admission to hospital, they were fully informed and that a staff member stayed with their relative during their entire admission to hospital.

Wherever necessary and reasonably practicable, interpreter services are provided. The majority of residents speak Mandarin or Cantonese, and state that all care staff can communicate effectively with the residents. An interpreter is provided for the auditors to assist with resident, family and staff interviews.

The ARRC requirements are met.

##### Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisational policy and procedures are implemented to ensure residents’ right to a fair and responsive complaints process is upheld. Interviews with three of three residents and two of two family/whanau members (via an official interpreter) confirm they are informed of and understand their rights related to making a complaint. No negative comments were received on the day of audit.

Residents and visitors have easy access to complaints forms which are available from the manager’s office, in a wall folder in the main corridor and in the downstairs lounge area.

The complaints register sighted identifies that only two complaints of a minor nature have been received to date for 2014. Documentation identifies the actions taken to gain a resolution. For example one complaint related to food services was resolved by holding a meeting with the weekend cook, the resident and the registered nurse (RN).

##### 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 business plan identifies the purpose, values, direction and goals of the organisation. It was last reviewed in August 2013 and the owner confirms he is currently organising dates for the 2014 review. The service conducts quarterly service reviews and documentation identifies that the last review covered policy updates, strategic objectives, hazard control, staff training and supervision and data collection review.

The manager has been at Abbey Heights for more than five years. He attends appropriate ongoing education both related to management and clinical areas. The manager is on a working group to translate more information into Chinese, such as information related to wound care management. He is supported by a registered nurse (RN) who works full time Monday to Friday and is on call as required. The RN manages all clinical aspects of care. As she is a newly appointed RN with limited experience, she stated she is supported by RNs from other facilities owned by the organisation and by the gerontology nurse practitioner from Waitemata District Health Board (WDHB).

##### 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 current policies and procedures in use are maintained by an off-site company who ensure all legislative requirements are met. Much of the information available, such as resident rights, the complaints policy and wound care management, is also available in Chinese to assist residents and their family/whanau understanding. Staff have access to hard copy policy and procedures which are kept up to date by the manager. Any changes to policy are sent to the service electronically (via ‘drop box’) and discussed at staff meetings before being placed in the policy folder.

Abbey Heights Rest Home implements quality and risk management systems that reflect the principles of continuous quality improvement. The quality and risk plan and the business plan show how key components of service delivery are measured via regular ongoing audits to identify areas where corrective actions may be required. Interviews with five of five staff ; registered nurse (RN), cook, caregiver, kitchen assistant and cleaner) confirm their understanding of the quality systems which are in place at the facility. Staff interviews and meeting minutes sighted show that any required corrective actions are discussed and implemented as required. Exception reporting sighted includes actions taken in response to quality data collection, health and safety, complaints management and incident and accident reporting. For example, following a resident fall, appropriate management actions, including ensuring the area is well lit, the removal of hazards and correct follow-up by the GP to investigate pain, were undertaken.

Audits are conducted as identified on the audit calendar and result findings are justified accordingly if there is a logical reason for no follow up being undertaken. For example not every folder has a signed advance directive and it is stated why this has occurred, such as the resident is not competent to sign the form or has chosen not to. Another example relates to how the service ensures residents have enough fluids available at all times to ensure urinary tract infection rates remain low. Corrective actions taken following a pharmacy medication packaging error are very detailed and easy to follow. The effectiveness of corrective actions is undertaken by the facility manager and the RN who both report to the owner.

The quality improvement data which is collected and evaluated is benchmarked against other like type facilities quarterly by a contracted company. Abbey Heights remains in the lower percentile for wounds, falls, urinary tract infections and skin tears. The February to May 2014 quarter identifies that there have been no medication errors or challenging behaviour issues reported.

Actual and potential risks related to the business operations are identified, documented and communicated to residents, family/whanau and staff as appropriate. The service has an up to date hazard recording system which identifies any hazards that are found and what actions have been taken to isolate, minimise or eliminate them. The facility manager stated that the health and safety policy is fully implemented, including hazard monitoring, to ensure a safe environment for all. Residents’ meetings minutes identify that the meetings are used as a forum to educate residents in issues such as emergency procedures and cough and cold etiquette.

The resident satisfaction survey undertaken in June 2014 identifies that residents are satisfied with the services provided and that staff treat them with respect at all times. No negative comments are sighted. The owner stated that if any negative comments are received they use this information to improve service delivery.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The manager is aware of his responsibilities with regard to reporting adverse or unplanned events to regulatory and statutory bodies.

All adverse or untoward events are recorded on incident and accident forms. A review of the incident forms for 2014 identify that all incidents are reported to family/whanau as appropriate. This is confirmed during interview with two of two family/whanau members.

Meeting minutes identify that incidents and accidents and related data are discussed at staff and management meetings. The information is used to improve services as appropriate, such as following a resident fall. Incident and accident data is benchmarked against previously collected data.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

**Attainment and Risk:** FA

**Evidence:**

Staff that require annual practising certificates have them validated prior to commencing work and annually thereafter. Current practising certificates are sighted for one GP, one physiotherapy clinic, the RN, the pharmacy and pharmacists.

At Abbey Heights 20 of the 21 residents speak either Mandarin or Cantonese and one resident speaks a Pacific language and English. The staff ethnic and language mix matches that of the residents. Interviews with three of three residents conducted with an approved DHB interpreter, did not identify any issues or concerns. This is confirmed by the 2014 resident satisfaction survey results sighted.

A review of five of five staff files and staff interviews confirm that the service offers an appropriate orientation and ongoing education programme. The service is well supported by WDHB. Education is offered both on-site and off-site by the gerontology nurse practitioner and via the WDHB residential care integrated programme. Annual appraisals are undertaken and allow staff to identify any specific educational needs. Documented staff education identifies appropriate areas of service delivery topics are covered over a 12 month period.

Resident and family/whanau interviews and the June 2014 resident satisfaction survey returns sighted confirm staff deliver services in a manner that meet residents’ needs.

##### 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:**

Provider levels and skills mix is implemented as stated in policy to meet safe service delivery staffing levels according to district health board requirements.

A review of six weeks rosters identifies that staffing numbers and skill mix is maintained at a constant level and that staff are replaced for sick leave and annual leave. Staff hold current first aid qualifications which are monitored by the facility manager to ensure they are kept valid. There is a RN on duty five days a week and on call at all times. The owner confirms that RN cover is maintained at all times and that there is a casual RN available to relieve the full time RN as required.

Staff report during interview that they have time to complete required tasks within rostered hours.

Interviews with three of three residents and two of two family/whanau members confirm they are happy with the standard of service provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The previous audit identified that the daily care log and report on the wellbeing of the residents does not record the time of the report or the designation of the staff. The area for improvement to ensure that all records record the time of entry and the designation of the service provider is identifiable is now addressed. The three of three residents files reviewed have the designation of the staff member recorded. The caregiver interviewed is aware of the requirement to include their designation.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

#### Standard 1.3.3: 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:**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced staff that are competent to perform the function. The RN conducts the nursing assessments and develops the care plan, reviews and evaluates the care, with input from the care staff, resident and where appropriate the family. A GP conducts the medical assessments and reviews. The caregivers have access to ongoing training and education applicable to the needs of the residents. The care staff are able to communicate in the language of the residents. The annual practising certificates are sighted for those staff and contracted staff that require one.

The service is using a mix of paper based and the electronic interRAI assessment tools. Eight of the current residents have an interRAI assessment. The paper based initial assessments include personal support needs, communication, diet, fluids, culture, spirituality, sexuality, mobility, pain relief, cognition, continence, skin and wound. The initial assessments also include pressure area risk, body chart for skin integrity, separate pain assessment, mini nutritional assessment, falls risk, geriatric assessment scale, manual handling assessment and a bladder chart. There is an initial care plan used for up to three weeks until the long term care plan is developed. The service utilises a standardised long term care plan which is individualised to the resident’s needs, their own individual long term care plan for other identified needs and short term care plan for temporary changes. The long term care plans identify the problem, aim, solution/interventions and review/evaluation. The needs identified on the long term care plan include assistance with personal care agreed with the resident (and where applicable the family), mobility, food and nutrition, continence, physical problems, rehabilitation, mood, sexuality and intimacy, social, cultural and recreational needs. Short term care plans identify the problem, aim, solution and review to evaluate if the interventions are working. The long term care plans record the required assistance with personal cares as agreed with the resident and family.

Interview with the RN confirms that the initial assessment and initial care plan are developed on the day of admission, the long term care plan is developed within three weeks and reviewed and evaluated at least six monthly. The residents are reviewed by a general practitioner (GP) at least three monthly, when the resident is assessed as stable. The GP is not available for interview at the time of audit. The three of three residents interviewed report a high satisfaction with the medical coverage and feel they are able to access the GP as required (interviews conducted with the aid of an interpreter).

Each resident has one file which includes the multidisciplinary team input into care. A daily record of care records interventions each shift. There is verbal handover between each shift. A communication book is also maintained to record appointments. The RN and one caregiver reports that there is an adequate handover to provide information for the continuity of care and report san excellent team approach to care.

Tracer example

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

The three of three residents and two of two family/whanau interviewed report high satisfaction with the care provided at the service.

The requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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:**

The service has adequate dressing and continence supplies to meet the needs of the residents. The three of three care plans reviewed record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The file of the rest home resident reviewed shows specific strategies for the identified needs. Another file reviewed has specific interventions for a resident with a history of re-occurring urinary tract infections (UTI’s). With the interventions that have been implemented, the resident has not had a UTI in the last two months.

The three of three residents and two of two family have high praise for the interventions at the service and that the service meets the needs of the residents.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The activities are provided by the care staff and management of the service, with input from visiting providers (for example, Thai Chi instructor). The activities are individualised and developed in conjunction with the resident, and where appropriate their family, with consideration of the cultural needs of the residents. The activities assessments and plans are recorded in the diversional therapy plan, as sighted in the three of three residents' files reviewed. The activities assessment includes social pursuits, cultural, intellectual interests, creative pursuits, physical activity, and outdoor interests. There is a monthly evaluation of how the resident is achieving their goals related to their diversional therapy activities. The three of three residents files reviewed have an additional review by a registered diversional therapist (all conducted in 2013), which summarizes the resident’s interests and likes related to social activities.

Where possible the resident’s independence is encouraged by maintaining links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet resident’s interests.

The three of three residents interviewed report they enjoy the range and variety of planned activities.

The ARRC requirements are met.

##### Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** FA

**Evidence:**

The three of three care plans reviewed evidence evaluations are recorded at least six monthly by the RN with input from the GP, care staff, the resident and the family when appropriate. The documented evaluations indicate the resident's progress in meeting goals, and care plans are updated to reflect progress towards meeting goals.

Where progress is different from expected, the service either updates the long term care plan or uses short term care plans for temporary changes. The three of three residents' files reviewed indicate they are updated to reflect changing needs of the resident. The three of three residents and two of two family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.

The ARRC 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.

**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:** PA Low

**Evidence:**

Medicines for residents are received from the pharmacy in a pre-packed medication delivery system. The signing sheet that records the packs are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. The service does not use standing orders.
Medicines are stored in a locked medicine cupboard on the lower level and with the medicine fridge located in the office area. The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines. There are no controlled drugs at the facility at the time of audit. There is an area for improvement to ensure ongoing processes are implemented to ensure expired medicines are destroyed or returned to pharmacy as appropriate (refer to 1.3.12.1).

The six of six medicine charts reviewed have been reviewed by the GP in the last three months; this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose and time of administration with any allergies highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed. All signing sheets are fully completed on the administration of medicines for the past four weeks.

There are documented competencies sighted for the caregivers responsible for medicine management, these are last recorded as occurring within the last 12 months. The RN does not have a documented medication competency (refer to 1.3.12.1).

The RN reports that there are no residents assessed as competent to self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines.

The ARRC requirements of D1.1g and D19.2d are partially met. The other ARRC requirements are met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A medication sighted in the medicine fridge expired in October 2011. This is removed at the time of audit. There is corrective action request to ensure there is ongoing monitoring and implementation of safe medicine management practices in relation to the storage and disposal of medicines.

**Finding:**

There was expired medicine in the medication fridge, which was removed at the time of audit.

**Corrective Action:**

Ensure there is ongoing monitoring and implementation of safe medicine management practices in relation to the storage and disposal of medicines.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Medicine management education is conducted twice to date in 2014. The one RN does not have a documented medicine competency; though they have attended the medicine management education (related to the medicine administration packs and one session conducted through the DHB). There is an area for improvement to ensure that staff who perform medicine management have current evidence of medicine competency.

**Finding:**

The RN does not have a documented competency for medicine management.

**Corrective Action:**

Ensure staff responsible for medicine management are assessed as competent to perform the function for each stage they manage.

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

The four week rotating menu, with seasonal variations, is approved by a registered dietitian in September 2011 as suitable for aged care residents. The menu review is based on the dietitian NZ audit tool for residents living in long term care and includes the cultural needs of the Chinese residents. The manager reports that there have been no major changes to the menu since the dietitian review. The daily menu is displayed on the notice boards, which includes a picture of the food and written in a language the residents understand.

A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. Residents who have additional or modified nutritional requirements or special diets have these needs met. For example, the service provides diabetic and texture modified diets to meet specific residents' needs. The service has one resident of a Pacific Island heritage and this resident has individually prepared foods that are culturally appropriate for this resident.

Aspects of food procurement, production, preparation, delivery and disposal comply with current legislation and guidelines. At the time of audit there are sighted opened bags of dried food (for example, flour) on a table at the end of the residents’ dining room and opened bags of dried foods sighted in the pantry. These opened packages are in food safe containers. This is addressed at the time of audit, with all opened food packs placed in plastic containers with lids; no further action required. Fridge and freezer recordings are undertaken daily and meet requirements. Staff have undertaken food safety education appropriate to service delivery.

The three of three residents and two of two family interviewed report high satisfaction with the food and fluids.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a current building warrant of fitness which was issued on 8 November 2013. There have been no changes made to the facility footprint since the previous audit.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate available toilet/shower and bathing facilities to meet residents’ needs. This was an area identified for improvement in the previous audit and is now fully attained. The bathroom areas have either been fully renovated or are on the long term maintenance plan for upgrade over the next 12 months. This includes the remodelling of all residents’ bedroom bathroom areas, with all downstairs bedrooms now having toilet and hand basin ensuites.

##### Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

**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:**

Policy identifies that enablers can be equipment, devises or furniture voluntarily used by residents (following an appropriate assessment) that limits normal freedom of movement to promote independence, comfort or safety. The service has no enablers or restraints in use. There is a gate on punch key opening at the entrance to the grounds and all residents and their family/whanau know the code to exit the gate. On the day of audit a resident opened the gate for the auditors.

Education records identify that all staff have attended education related to management of challenging behaviour in the past 12 months. This is confirmed during staff interviews as staff can verbalise what an enabler is and the state no enablers or restraints of any kind are used at the facility.

##### 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:**

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The surveillance data is gathered for the rest home level of care residents. The monthly report of collected data is provided to senior management and presented at staff meetings. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme. The surveillance data is benchmarked with other aged care services through an external aged care advisory service.

All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for 2014 records an increase in chest infections and colds in June and July 2014. The analysis records that this is reflective of seasonal and community norms. The analysis records that when possible residents are asked to stay in their rooms as much as possible, so not to expose others to infections, the cleaning of residents’ rooms is increased, residents are encouraged with increased fluid intake, family and friends were asked to wash their hands before and after contact with the residents and resident education is conducted at the resident meeting regarding cough etiquette.

It is noted that on the record of antibiotic administration that 36 lots of antibiotics were prescribed in June and July 2014 for the 'common cold'. This is discussed with the manager and RN at the time of audit. The infection control coordinator (RN) reports that they have discussed the antibiotic use with the GP, and reports that the GP feels that all the antibiotics are appropriately prescribed. The service may wish to further review the prescribing with the GP to ensure the prescribing and giving of antibiotics is reflective of current accepted good practice.

##### 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.)*