

Ativas Limited

Current Status: 13 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

Cairfield House provides rest home and hospital level care for up to 64 residents. Occupancy on the day of audit included nine hospital level residents, 45 rest home residents and six respite rest home residents. The service continues to implement a quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced manager who is supported by a clinical manager (registered nurse) and the owners. Registered nurses are on duty each shift. The manager reports that staff turnover is low. The service continues to provide care to residents based on the services mission and philosophy of care. Staff interviewed and documentation reviewed identifies the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed all seven of the previous shortfalls identified at the previous partial provisional and certification audit.

This surveillance audit identified two shortfalls relating to employee contracts and evaluations of care plans.

Audit Summary as at 13 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

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

Consumer Rights as at 13 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 13 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

Continuum of Service Delivery as at 13 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 13 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 13 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 13 August 2014

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

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:	Ativas Limited
Certificate name:	Ativas Limited

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

Types of audit:	Surveillance Audit
Premises audited:	Cairnfield House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 August 2014 End date: 13 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:	60
---	----

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	5
---------------------	-------	----------------------	---	-----------------------	---

Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

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

Number of residents interviewed	6	Number of staff interviewed	13	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	41	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Friday, 12 September 2014

Executive Summary of Audit

General Overview

Cairfield House provides rest home and hospital level care for up to 64 residents. Occupancy on the day of audit included nine hospital level residents, 45 rest home residents and six respite rest home residents. The service continues to implement a quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced manager who is supported by a clinical manager (registered nurse) and the owners, registered nurses are on duty each shift. The manager reports that staff turnover is low. The service continues to provide care to residents based on the services mission and philosophy of care. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed all seven of the previous shortfalls identified at the previous partial provisional and certification audit.

This surveillance audit identified two shortfalls relating to employee contracts and evaluations of care plans.

Outcome 1.1: Consumer Rights

There is an open disclosure policy in place to guide staff practice. Family are kept informed of their family member's current health status including any adverse events where appropriate. There is a record in each resident's clinical record as to when family wish to be contacted. A complaints process is implemented.

Outcome 1.2: Organisational Management

The facility manager is a registered diversional therapist who commenced employment at the facility 21 years ago as a caregiver and has progressed through various roles since then becoming the facility manager in September 2013. She is supported by a clinical care manager who is a registered nurse with a current practising certificate and experience in the aged residential care industry. The clinical care manager is employed 32 hours per week (i.e., 4 days week). A registered nurse provides clinical management cover for the other three days of the week when the clinical manager is not on site. There is a team of registered nurses who provide 24 hour cover who in turn are supported by a team of experienced health care assistants. The service continues to implement a quality and risk management framework that includes management of incidents, complaints, hazards, consumer complaints and infection prevention and control data. There is an implemented internal audit programme to monitor outcomes. Staff are orientated and inducted following appointment. There is an in-service training schedule in place. The service has sufficient staff allocated to enable the delivery of care. The service has addressed the shortfall related to human resource management identified during the previous partial provisional audit conducted in January 2014. This audit identified a further improvement related to human resource management.

Outcome 1.3: Continuum of Service Delivery

Assessments and care plans are completed by the registered nurses. Short term care plans are utilised for changes in health status such as infections and wounds. Care plans are goal oriented, comprehensive and detail the interventions required to meet resident's needs. An improvement is required whereby care plans are reviewed at least six monthly or when healthcare needs change. Residents and family interviewed described being involved in the care planning process and they were informed of any changes in health care status. Activities are varied, meaningful and include inclusion at local community and entertainment events. Activity plans contain goals and interventions to assist resident reach the desired outcome. The programme for rest home and hospital residents is varied and involves the wider community. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are reviewed by the general practitioner three monthly or earlier if necessary. Medications were observed to be managed and administered appropriately. The service has addressed and monitored the previous findings relating to medication management. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Improvements have been made in relation to nutritional assessments and maintaining correct temperatures of the island fridge. There are food service policies and procedures and a link to a dietitian. All food is cooked on site and residents interviewed were very complimentary of the variety and choice of food available on the menu.

Outcome 1.4: Safe and Appropriate Environment

Cairnfield House has a current building certificate that expires on 1 January 2015. Improvements have been made in relation to servicing of equipment and monitoring and recording of hot water temperatures.

Outcome 2: Restraint Minimisation and Safe Practice

The service has a no restraint policy and there were no residents assessed as requiring restraints or enablers. Staff attend restraint minimisation and safe practice education and complete competencies. A restraint register and appropriate documentation is available to record assessment, consent, planning and monitoring of restraint/enablers should the need arise. The restraint minimisation programme is reviewed six monthly.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control co-ordinator, who is a registered nurse, is responsible for the surveillance programme. Policies and procedures document infection prevention and control surveillance methods. Surveillance data are collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at monthly staff/ including infection control meetings. Detailed information on the type of infections, treatment, duration of treatment and its effectiveness are recorded. Resident's infection trends are identified and recorded, any corrective actions are acted upon as sighted in the meeting minutes.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	1	0	0
Criteria	0	40	0	1	1	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	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	The employment process and management of employment records are not consistent with good employment practice which meets the requirements of employment legislation.	Review the current employment process and management of employment records to ensure they are consistent with good employment practice which meets the requirements of employment legislation.	30
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		comprehensive and timely manner.				
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	a) One rest home resident care plan has not been evaluated since it was re-written in December 2013; b) Two hospital resident care plans had not been updated following a change in cares. One resident now has an indwelling catheter which was not recorded on the care plan. One resident was admitted in July 2014 and was previously independent with some cares. The resident is now receiving XXXXX however, the care plan has not been updated to reflect this.	a) Ensure all care plan evaluations are conducted; b) ensure that care plans are updated to reflect the current care requirements for all residents.	60

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; D16.1bij; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. The forms to record incidents and accidents include a tick box area to indicate if family have been informed (or not) of any accident/incident. All 27 incident forms and accident forms were reviewed for July 2014. There is evidence of open disclosure occurring on the incident forms and in the resident's clinical records. Communication preferences of families and next of kin are recorded in the resident's records. Relatives interviewed (one rest home and three hospital) confirm they are notified following a resident incident. Education on consumer rights was last provided in February 2014 attended by 11 staff.

D13.3 The admission agreement is based on the NZ Aged Care Association template.

D 16.4 Staff are notifying the family as soon as possible if a resident's health changes.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a concerns and complaints policy to guide practice, which is documented and complies with Right 10 of the Code of Health and Disability Services Consumers' Rights. The manager leads the investigation and management of all consumer complaints. There is an up-to-date complaints register that includes all complaints, dates, and actions taken. There have been no complaints received since the previous audit in January 2014. One family have raised concerns about staff not responding to call bells and the food within two days of admission. However, the family have expressly indicated that they did not want the matter treated as a complaint. Management met with the family and resolved the matter to their satisfaction (evidence sighted). Staff are aware of the consumer complaints process (confirmed in discussions with six of six health care assistants, who cover all shifts and two of two cleaners). Education on consumer rights including complaints management was last provided in February 2014 attended by 11 staff. An internal audit of the code was conducted in February 2014 with no corrective actions identified.

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 facility is owned by Ativas Limited and managed by a fulltime facility manager. The owner maintains an onsite office and is present most days. There is a business plan for 2014 that outlines objectives and actions for the period. The purpose, values, scope, direction, and goals of the organisation are clearly identified in a variety of documents and regularly reviewed. The mission statement was last reviewed in July 2014. Care is provided for up to 66 residents across two service levels (i.e., rest home and hospital). On the day of audit there were 51 rest home residents and nine hospital level residents living in the premises.

There is a quality and risk management programme in place that includes discussion about clinical indicators (e.g., incident and accidents, and infection rates) at the monthly staff meeting. The monthly staff meeting was held on the day of audit (and was attended briefly). The facility manager is a registered diversional therapist who commenced employment at the facility 21 years ago as a caregiver and has progressed through various roles since then. She was appointed to the role of facility manager in September 2013 (although she has no offer of employment to the position on her employment record and has not signed a current employment agreement- Link 1.2.7.). She is supported by a clinical care manager who is a registered nurse with a current practising certificate and experience in the aged residential care industry. The clinical care manager is employed 32 hours per week (i.e., 4 days week). A senior registered nurse provides clinical management cover for the other three days of the week when the clinical manager is not on site. There is a team of registered nurses who provide 24 hour cover who in turn are supported by a team of experienced health care assistants.

The organisational structure is clearly defined and this is an improvement on previous certification.

D17.3 (d) (i) & D17.4 (b) (i): the manager has maintained at least eight hours annually of professional development activities related to managing an aged residential care facility (certificates of attendance at relevant training sighted).

D 17.5: The facility manager has a background in management and is a registered diversional therapist. She acts as manager of both the rest home and hospital area as services are delivered as a single facility. She is supported by a clinical care manager who is a registered nurse.

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:**

There is an established quality and risk management system in place which is understood and implemented by staff (confirmed in discussions with the clinical care manager, six of six health care assistants). The system includes but is not limited to: a suite of policies and associated procedures and forms, systems for the management of care, systems for medicine management, the management of consumer complaints, hazards, adverse events, health and safety of people on the premises, infection prevention and control. The quality management and business plan was last reviewed June 2014. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed in line with best practice, and the manuals are updated when policies have been reviewed. Policies are reviewed at least two yearly or earlier as defined by the documentation recording policy. The collection of quality improvement data includes incidents, accidents, infections, health and safety, hazards, results of internal audits and satisfaction. Data is analysed by the facility administrator, the facility manager and the clinical care manager. Discussion about clinical indicators (e.g., incident and accidents, infection rates, complaints and quality improvements occur at the monthly staff meetings (minutes sighted and staff meeting attended briefly on the day of audit). Corrective actions are identified and progress documented.

The business and quality improvement plan 2014 identifies objectives for quality improvement at the strategic level and these are monitored at business management meetings attended by the facility manager and the director and clinical manager. These meetings happen formally each week and informally on a daily basis (meeting folder sighted). Quality and risk management monitoring occurs through the business management meetings. The facility operates an internal audit programme which is managed by the clinical care manager. The internal audit programme covers a mix of business, organisational and service delivery plus the environment. The internal audit programme has a number of scheduled audits for each calendar month. Issues arising from internal audits are documented on an audit register and there is evidence of identified corrective actions having been addressed. Internal audits in 2014 have included audits of the group recreation programme, the Code of Rights, Lifting/Transferring of residents, a preferred suppliers audit, the laundry, the food service, a post discharge audit, a 6 week post admission audit, consumers with challenging behaviours, privacy, residents records, medicine management and care planning.

D19.4 (b) there is a documented quality improvement plan which is implemented, evaluated for effectiveness and corrective actions are processed.

D19.4 (d): The services are monitored against the quality improvement plan which includes resident satisfaction surveys, internal audits and external reviews through the DAA process.

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 facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications and major adverse events.

D19.3c: The service collects incident and accident data and reports aggregated figures are reported monthly to the staff meeting. Incident forms are completed by staff. The resident is reviewed by the registered nurse at the time of event. The form is then reviewed by the clinical care manager and/ or the facility manager as appropriate. Family are required to be notified by the registered nurse. All 27 incident forms for July 2014 were reviewed. All events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner according to the resident and family preferences.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to staff so that improvements are made. Trending data are considered.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There are human resources policies to support recruitment practices. Copies of current practising certificates are held on file (sighted). Five staff files were reviewed (i.e., the facility manager, the clinical care manager, an enrolled nurse, and two health care assistants one of whom is the health and safety officer and the other who is new employee).

A review of the employment records evidenced that the employment process is not consistent with good employment practice and employment legislation, as outlined by the Ministry of Business, Innovation and Employment (link 1.2.7.3). The service has an orientation programme in place that provides new staff with information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). The finding from the previous audit related to the need to update the orientation programme to include hospital care and registered nursing orientation has been met. All registered nurses have been orientated by the clinical care manager (records sighted for four newly employed registered nurses). Staff interviewed (six health care assistants who work all shifts, two cleaners, one activities coordinator, one cook, one registered nurse, and one enrolled nurse) were able to describe the orientation process and believed new staff were adequately orientated to the service. There is a yearly education plan in place for 2014 (sighted). The previous audit noted that the training plan for 2014 had not been completed. This finding is now met. Records of attendance at annual in-service training and off site education are maintained (sighted). Medication competencies are in completed annually for registered nurses and other care staff who are administering medication by the clinical care manager (sighted). There is a system for performance appraisals in place which re-commenced March 2014 following a period of neglect. The current system is managed by the clinical care manager. The clinical care manager has just recently taken over the role of ensuring performance appraisals are conducted annually. She has been concentrating on getting the registered nurses orientated and has completed three monthly performance appraisals for them and is now working through the health care assistants. Professional qualifications are validated, including evidence of registration

and scope of practice for service providers (sighted). Employment records are filed loosely in no particular order in folders. There is no system of checking that all relevant employment documents are held by management creating a risk of papers being lost or mislaid. An improvement is required.

D17.6 (c): Health care assistants have completed training that is relevant to the care of older people. New staff commence training at orientation.

D17.6 (d): Staff demonstrate competencies and follow documented policies and procedures and are supervised by the registered nurses

D17.8: There is an ongoing programme of staff development and a written record is kept of staff attendance at these programmes. The previous audit noted that the registered nurse job description was not updated to relate to hospital level care. This corrective action has been addressed and is now met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

A review of the employment records for a sample of five staff members evidenced that the employment process is not consistent with good employment practice which meets the requirements of legislation. For example there is no evidence that the facility manager was offered the current position, entered into a formal agreement for the change in her working conditions, and signed a current job description for the role, and that the clinical care manager was offered the current position, entered into a formal agreement for the role and signed a current job description for the role, and that the recently appointed health care assistant had no reference checks although she did have a NZ Police check and there is no evidence of an offer of employment. All employment records are loosely filed in no particular order, which is a risk to the business and is not accepted good employment practice.

Finding:

The employment process and management of employment records are not consistent with good employment practice which meets the requirements of employment legislation.

Corrective Action:

Review the current employment process and management of employment records to ensure they are consistent with good employment practice which meets the requirements of employment legislation.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery (policy sighted). There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Staffing is as follows:

6.45 am to 3 pm: the hospital area is staffed by a registered nurse and two healthcare assistants. They are supported by a float healthcare assistant from 6.45 am to 11 am. The rest home is staffed by three healthcare assistants.

2.45 pm to 11 pm: the hospital area is staffed by a registered nurse and two healthcare assistants. They are supported by a float healthcare assistant from 4 pm to 8 pm. The rest home is staffed by three healthcare assistants.

10.30 pm to 7.15 am: The facility is staffed by one registered nurse and two healthcare assistants who work from 10.45 pm to 7.15 am.

As acuity in the hospital area increases the number of care staff is expected to increase. Currently there are only nine hospital level residents currently and the acuity of the rest home residents are quite mobile and cognitively aware.

The healthcare assistants, residents and relatives interviewed report that there are sufficient staff on duty at all times (confirmed in discussions with six residents (four rest home, two hospital), four relatives (three hospital and one rest home) and six of six health care assistants.

D16.5 (b), D16.5 (c) (i) & D17.1 (a): Staff are available at all times to meet the needs of residents.

D17.3 (a) (b), (c), (d) (ii),(e), (f),& (g): The 41 bed rest home beds are staffed appropriately with at least two health care assistants on duty at all times.

D17.4 (a), (b) (ii), (c),&(d):The 25 bed hospital facility is staffed appropriately with at least one registered nurse on duty at all times and one facility manager on duty each working day. The registered nurses are responsible for developing the initial care plans for residents within 24 hours of admission and developing the long term plan within three weeks of admission, and the staffing ratio complies with the terms of the ARC agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA**Evidence:**

The registered nurses at Cairnfield House are responsible for development of long term care plans with input from health care assistants. Admission assessment and short term care plans is completed within 24 hours of admission (six of six resident files reviewed – three rest home and three hospital). Evaluations and reviews are completed by the registered nurse six monthly for one rest home and one hospital resident file reviewed (two hospital and one rest home residents admitted within the last six months). One rest home resident care plan has not been evaluated since it was re-written in December 2013. Two hospital resident care plans had not been updated following a change in cares (link #1.3.8.3). Care plan reviews are conducted by a registered nurse with input from the care staff, activities coordinator, general practitioner (GP) and relatives, and occur to review all aspects of the residents care and support requirements. Re-assessments are completed at care plan review. The long term care plan is developed within three weeks of admission as evidenced in five of six files reviewed (one rest home respite). A comprehensive assessment includes pain, mobility, personal hygiene, elimination, communication, activities, nutritional, sleeping, skin, pressure area risk, falls, behaviours, mini nutritional and mini mental assessment. Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the care plan. Communication with family is documented on a family communication sheet or in the progress notes. A verbal and written handover occurs at the end of each shift. Staff are informed of any care plans that have been updated at handover. Care plans are signed off by a registered nurse, the resident and/or family member. Medical assessments are completed within two working days of admission by the GP as evidenced in five of six files sampled (one respite). It was noted in residents files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. On interview the house GP stated that the service contacted her in a timely manner, providing information required to assess the residents. The service always carried out any observations and interventions as prescribed. The service has recently commenced using InterRAI and the clinical manager reports that she has completed the training. Two registered nurses are in the process of completing the training. The use of the interRAI tool was not evident in the any of the six files reviewed. Long term care plans reviewed for six of six resident's sampled evidenced comprehensive and resident focused goals and interventions. All six files identified integration of allied health.

Tracer Methodology Rest Home:

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

Tracer Methodology Hospital:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Previous partial provisional audit identified that mini nutritional assessments had not been signed or dated when completed. Six resident files were reviewed and included three rest home and three hospital residents. In six of six files sampled, an initial nursing assessment and initial care plan was completed within 24 hours of admission. A comprehensive assessment is completed and includes pain, mobility, personal hygiene, elimination, communication, activities, nutritional, sleeping, skin, pressure area risk, falls, behaviours, mini nutritional and mini mental assessment. All evidenced completion and sign off by the registered nurse. The comprehensive assessment was completed in five of six files reviewed (one respite rest home resident). The assessment information gathered is used to plan resident goals and outcomes. Assessments are conducted in an appropriate and private manner. Residents and family members interviewed report being very satisfied with the support provided. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. The service has addressed and monitored this previous finding.

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

Standard 1.3.6: 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:

Cairnfield House provides services for residents requiring rest home and hospital level care including respite care. There were six respite residents in the service on the day of audit all with chronic mental health issues. Individual care plans are completed. The six health care assistants, one registered nurse and one care manager interviewed stated that they have all the equipment referred to in the long term and short term residents care plans necessary to provide the care required. These include wheelchairs, walking frames, weighing scales, transferring equipment, pressure relieving equipment, residents safety equipment, electric beds, continence supplies, gowns, masks, aprons and gloves. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There is a large well stocked treatment/medication storage room.

There are currently 10 wounds being treated including two pressure areas – both acquired by the residents prior to admission to Cairnfield. Wound assessment and management plans are documented for all wounds including ulcers, skin tears, and pressure areas. The registered nurse and care manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse. One resident is under the care of the district nursing wound care service and one is under the care of a vascular clinic. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Wound management in-service has been provided in February 2014.

All falls are reported on the incident forms and reported to the care manager. Falls risk assessment is completed on admission and reviewed six monthly or earlier should there be an increased falls risk. A physiotherapist is available to be contacted if and when required.

There are registered nurses employed 24/7 by the service as well as a care manager who oversees the rest home and hospital residents. A record of all health practitioners practising certificates is kept. Resident's needs are assessed using pre admission documentation, doctor's notes and the assessments tools which are completed by a registered nurses. Care plans are goal orientated and reviewed six monthly. Care plans are updated to reflect intervention changes following review or change in health status (with exceptions link #1.3.8.3).

During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents and relatives interviewed were able to confirm that privacy and dignity was maintained.

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

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

Attainment and Risk: 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:

There is one activities coordinator at Cairnfield House who are responsible for the planning and delivery of the activities programme. The activities coordinator is employed for 35 hours per week. Activities are held between 9am and 4.30 pm. There is one activities programme which caters to the abilities and interests of both rest home and hospital level residents. The programme includes newspaper reading, exercises, housie, happy hour, bowls, games, and visits to and from other rest homes, concerts, drives and van outings. The hospital residents enjoy newspaper reading, exercises, happy hour, balloon and ball games, debates and discussions, reminiscing, word find games, arts and crafts, shopping, cards, church services, bible study group and quizzes. There is a large recreation room adjacent to the rest home/hospital lounge. Activities are provided in the lounge, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events with family involvement. Of the six files reviewed, six files evidence that activities profiles, goals and plans are developed and reviewed at care plan review.

The programme also includes residents being involved within the community with social clubs, churches and schools. A record is kept of individual resident's activities and monthly progress notes completed. Participation in all activities is voluntary. The activity programme is displayed on two resident's notice boards. Eight residents and eight relatives advised that the programme is interesting and varied and meets the resident's needs.

Cairnfield House has its own van for transportation. The activity coordinator has a current first aid certificate.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

All initial care plans were developed by the registered nurse on the day of admission and residents comprehensive long term care plan developed within three weeks of admission. Evaluations and reviews are completed by the registered nurse six monthly for one rest home and one hospital resident file reviewed (two hospital and one rest home residents admitted within the last six months). One rest home resident care plan has not been evaluated since it was re-written in December 2013. Two hospital resident care plans had not been updated following a change in cares. Improvements are required in this area. Evaluations are conducted by a registered nurse with input from the care staff, activities coordinator, general practitioner (GP) and relatives, and occur to review all aspects of the residents care and support requirements. Care plan reviews are signed as completed by the registered nurse. There is at least a three monthly review by the medical practitioner or when requested if issues arise or health status changes. One GP interviewed stated that the communication from the service is appropriate and in a timely fashion and that the service carries out instructions. She advised that she has confidence in the skills and knowledge of the registered nurses and management team to safely care for residents. Short term care plans (STCP) were evident for current and previous wounds, skin tears and urinary tract infections. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Healthcare assistants interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

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: PA Low

Evidence:

All initial care plans were developed by the registered nurse on the day of admission and residents comprehensive long term care plan developed within three weeks of admission. Evaluations and reviews are completed by the registered nurse six monthly for one rest home and one hospital resident file reviewed (two hospital and one rest home residents admitted within the last six months). Evaluations are conducted by a registered nurse with input from the care staff, activities coordinator, general practitioner (GP) and relatives, and occur to review all aspects of the residents care and support requirements. Care plan reviews are signed as completed by the registered nurse.

Finding:

a) One rest home resident care plan has not been evaluated since it was re-written in December 2013; b) Two hospital resident care plans had not been updated following a change in cares. One resident now has an indwelling catheter which was not recorded on the care plan. One resident was admitted in July 2014 and was previously independent with some cares. The resident is now receiving XXXXX, however, the care plan has not been updated to reflect this.

Corrective Action:

a) Ensure all care plan evaluations are conducted; b) ensure that care plans are updated to reflect the current care requirements for all residents.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accordance with the guidelines: 2011 medicines care guides for residential care.

The service has policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by the GP. Cairnfield House uses a four weekly robotic pack system. Medication charts record prescribed medications by the residents' general practitioners and these are kept in the medication folders – two for rest home residents and one for hospital residents. The medication folders include specimen signatures for medication competent staff and GP's. There is a signed agreement with the pharmacy. Medications are delivered by the pharmacist and are checked on arrival by a registered nurse and recorded on a medication reconciliation form. Any pharmacy errors are recorded and fed back to the supplying pharmacy. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. The medication chart has alert stickers for allergies and duplicate names as evidenced in 12 medication files reviewed (six rest home and six hospital). Medication for use as required (PRN) is charted with reasons for giving documented. Management of XXXXX, and PRN controlled drugs are all recorded appropriately.

Previous partial provisional audit identified findings relating to medication management and included administering prescribed medications, indications for use documented for PRN medication and secure storage of medications. The service has addressed and monitored these previous findings.

Education on medication management occurred in March 2014. Registered nurse and senior caregiver competencies include blood sugar monitoring, controlled drugs, medication administration, and insulin administration. Registered nurses also complete two yearly syringe driver competency. A tracking process is in place to ensure competencies are completed and this is managed by the clinical manager. One registered nurse in the hospital, and one enrolled nurse in the rest home were observed administering medications safely – checking the medication chart against the medication pack, identifying the resident, observing the resident taking the medications and signing that they were given. For rest home residents, either an enrolled nurse, senior health care assistants or an RN administer medications; or only registered nurses administer medications to hospital residents.

Medication charts have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and prn medication. There are no residents self-medicating at Cairnfield House.

There are two medication trolleys, one in the rest home, and one in the hospital unit. The rest home trolley is kept in the locked medication/treatment room and the hospital trolley is locked when not in use and kept in the locked nurse's station. Controlled drugs for all residents are stored in a locked safe in the locked medication/treatment. Two medication competent persons must sign controlled drugs out – one of whom must be a registered nurse. There is evidence that a six monthly drug stocktake has been completed and weekly checks are conducted. Staff sign for the administration of medications on medication signing sheet. There were no expired medications sighted in either the medication trolleys or the medication/treatment room. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

Cairnfield House has a well equipped kitchen. All food is cooked on site. There is a food services manual that ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. A tour of the kitchen noted cleanliness and order in the pantry and fridges complying with guidelines. The service employs two cooks and kitchen hands. Both cooks have completed unit standards 167 and 168 and all kitchen staff have completed food safety training, infection prevention education and safe chemical handling.

Previous audit finding around the island fridge temperature monitoring and corrective actions has been addressed and monitored. All fridges and freezer temperatures are recorded daily on the recording sheet which was sighted and are within the required ranges for safe food storage. Food temperatures are recorded daily. Dish washer temperature is recorded daily. Dry food stuffs are stored in a storage area in the kitchen. All food was covered and stored on shelving above floor level. All meals are plated and covered and delivered to each area of the service at meal times. The island fridge which has previously recorded higher than acceptable temperatures has been modified to limit the sliding doors opening. Corrective actions have been implemented and the service has made improvements in this area.

A nutritional profile for each resident is completed on admission and updated as required. A meal card is then developed for the individual regarding likes and dislikes, allergies, meal size and portions, with options for diabetic, pureed, soft, thickened fluids and vegetarian. There is an external provider dietitian available for individual resident

need. The six weekly winter and summer menu is designed by the food services manager and head cook and thereafter approved by a registered dietitian (May 2013). Diets are modified as required. One hospital resident is receiving PEG feeds and the kitchen records show that residents who require them are receiving thickened fluids, and supplements. Staff were observed assisting residents with meals and drinks in the dementia unit and hospital unit. Eleven residents interviewed (seven rest home and four hospital) were very complimentary about the food provided and like the variety of the menu. Resident satisfaction survey which includes food was completed in April 2013 and showed overall satisfaction with the food service. Weights are monitored monthly or more frequently if indicated. Residents with weight loss issues receive nutritional supplements and food intake is monitored when required. The GP has requested that one hospital resident be weighed daily and this has occurred as evidenced in the file reviewed. There is evidence that there is additional nutritious snacks available over 24 hours in dementia unit including sandwiches, fruit, biscuits and drinks. There is sufficient stores of food for emergencies for up to five days.

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 displays a current building warrant of fitness which expires on 1 June 2015. Previous partial provisional audit finding around servicing of the hoists and hot water temperatures has been addressed and monitored. Hoists were last checked and serviced in February 2014. Hot water temperature records reviewed evidenced monthly checks on a random sample of resident's rooms which were all within the acceptable limits.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Cairnfield House has policies and procedures on restraint minimisation and safe practice. The care manager is the restraint coordinator at Cairnfield House. Policy states that enablers are voluntary. There were no residents assessed as requiring restraint or enablers. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers. Documentation includes a restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms should these be required.

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:

The infection prevention and control (IPC) co-ordinator is a registered nurse who is responsible for the surveillance programme which is incorporated into the infection prevention and control programme outlined in the IPC manual. Policies and procedures document infection prevention and control surveillance methods. Surveillance data are collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at monthly staff/ including infection control meetings. Detailed information on the type of infections, treatment, duration of treatment and its effectiveness are recorded. Resident's infection trends/patterns are identified and recorded. Any corrective actions are acted upon as sighted in the meeting minutes. The surveillance programme is appropriate to the size and complexity of the facility.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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