

Roseanne Retirement Limited

Current Status: 28 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

Roseanne House has residential care for up to 16 residents requiring rest home level care. Occupancy during the audit was 16 residents.

There is an implemented quality process and training plan. The service is owned and managed by a registered nurse and supported by a stable staff. All family and residents interviewed spoke positively about the care and support provided by staff and management.

Ten of twelve shortfalls identified from the previous audit have been addressed around human resource processes, cultural training, the availability of resident information, care plan interventions, aspects of medication management, infection control, complaints register, the quality, risk and business plan. Improvements continue to be required around documenting corrective action plans following internal audits and admission agreements.

This audit identified further improvements required around the complaints process, internal audits, incident forms, medication management, wound documentation, the restraint process and activities care plans.

Audit Summary as at 28 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 28 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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 28 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 low risk.
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Continuum of Service Delivery as at 28 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.
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Safe and Appropriate Environment as at 28 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.
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Restraint Minimisation and Safe Practice as at 28 August 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Infection Prevention and Control as at 28 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>
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HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Roseanne Retirement Limited
Certificate name:	Roseanne Retirement Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Roseanne Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 August 2014 End date: 29 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:	16

Audit Team

Lead Auditor	XXXXXX	Hours on site	12	Hours off site	6
Other Auditors		Total hours on site		Total hours off site	
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	12	Total audit hours off site	8	Total audit hours	20
Number of residents interviewed	3	Number of staff interviewed	8	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	15	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXXX, 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 Wednesday, 1 October 2014

Executive Summary of Audit

General Overview

Roseanne House has residential care for up to 16 residents requiring rest home level care. Occupancy during the audit was 16 residents.

There is an implemented quality process and training plan. The service is owned and managed by a registered nurse and supported by a stable staff. All family and residents interviewed spoke positively about the care and support provided by staff and management.

Ten of twelve shortfalls identified from the previous audit have been addressed around human resource processes, cultural training, the availability of resident information, care plan interventions, aspects of medication management, infection control, complaints register, the quality, risk and business plan. Improvements continue to be required around documenting corrective action plans following internal audits and admission agreements.

This audit identified further improvements required around the complaints process, internal audits, incident forms, medication management, wound documentation, the restraint process and activities care plans.

Outcome 1.1: Consumer Rights

Residents and staff report full information is provided at entry to residents and family/representatives. Regular contact is maintained with family. There is a complaints register that is up to date. Individual complaints documentation is an area for improvement.

Outcome 1.2: Organisational Management

The service has purchased and is implementing a new quality programme. This includes business and quality planning, policies and audit schedules. There is a system of meetings to ensure communication and review of quality outcomes occurs.

Incidents and accidents are collected and collated monthly. They are reported through to meetings along with complaints, infections, health and safety and restraint. Monthly audits are reported to meetings.

Human recourse processes are in place along with a comprehensive training programme. All new staff receive an orientation that provides staff with relevant information for safe work practices. There is a documented rationale for determining staffing levels for safe service delivery.

Rosters implement the staffing rationale and staff report management are responsive to any change in workloads.

The following improvements are required around; completion of internal audits and corrective action planning following audit, the documentation of RN review and communication with families following incidents.

Outcome 1.3: Continuum of Service Delivery

The service has implemented a new care planning format which is comprehensive and appropriate for rest home level care. Service delivery plans demonstrate service integration. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly. Interventions including activities of daily living, management of weight loss and management of challenging behaviours are well documented and implemented.

Activities provided for residents are varied, age appropriate and include inclusion at local community and entertainment events.

The medication management system is appropriate. Staff responsible for medication administration are trained and monitored. Medications are reviewed by the residents' general practitioner at least three monthly. Individual resident's medication charts were sighted.

The menu is designed and reviewed by a registered dietitian annually. Residents have had a nutritional profile developed on admission this is reviewed six monthly as part of the care plan review.

Areas for improvement were identified around; admission agreements, wound care plans, medication management and individual activities plans.

Outcome 1.4: Safe and Appropriate Environment

Building maintenance is carried out when necessary and records maintained. The building holds a current warrant of fitness. Hot water is monitored and records show these are maintained within safe limits.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint management policies and procedures are comprehensive; include definitions, processes and use of enablers.

The Restraint Minimisation Manual identifies that enablers are voluntary and the least restrictive option. There is one resident with an enabler at the time of the audit. Training has been provided. An improvement is identified around six monthly review of the enabler in use.

Outcome 3: Infection Prevention and Control

The Health and Safety meeting and quality meetings acts as infection prevention and control committee meeting and the statistics are tabled. Surveillance methods and processes including individual infection reports adequately identify the needs of the residents. Internal audits are completed.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	8	0	0	0
Criteria	0	39	0	8	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	29
Criteria	0	0	0	0	0	0	0	54

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.1	The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	There is no formal acknowledgement of complaints or formal reply and closure of complaints for the complaints on file.	Ensure that complaints are formally acknowledged according to the policy	30
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to	PA Low	A review of the audit schedule and audits evidences that audits are	Ensure corrective audits are undertaken according to the schedule and action plans are	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		meet the specified Standard or requirements is developed and implemented.		not always undertaken. The previous audit finding of corrective action not always documented remains a finding	developed when service shortfalls are identified.	
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Three of six resident related incident forms do not document family communication and three of six resident related incident forms do not document follow-up and review by a registered nurse (RN).	Ensure that family communication is documented following an incident and RN review is documented following an incident.	30
HDS(C)S.2008	Standard 1.3.1: Entry To Services	Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	PA Low			
HDS(C)S.2008	Criterion 1.3.1.4	Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.	PA Low	Only new resident have been provided with the new agreement.	Ensure that all resident have a copy of the new admission agreement to sign.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Two pressure sores have no formal wound assessment documented and one skin tear has no formal assessment documented	Continue to fully implement the new wound care templates and ensure that all wounds have a formal assessment, and management plan	30
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Two of five resident files reviewed did not have a documented individualised activity plan. Of the three residents with an individualised activity plan, one was not sufficiently documented to provide activity guidelines to staff.	Ensure that all residents have an individualised activity plan that reflects their recreation needs.	60
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	The medication charts and the controlled drug medication book reviewed. There is one instance in the controlled drug book with only one staff signature. There is one medication chart where a staff member has not signed for administration of regular medications	Ensure there are two staff signatures for all controlled drug medications. Ensure that staff sign for all medication on administration.	30
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 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.	PA Low	There is no documented review of the resident and the enabler.	Ensure that all residents with enablers have six monthly review of the enabler as per policy	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

The previous audit evidenced that cultural and spiritual aspects of care are not documented in the care plans. This audit evidenced that five of five care plans reviewed all included cultural and spiritual aspects of care.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

There is an open disclosure policy, a complaints policy and an incident and accident policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Seven of seven incident forms reviewed identify family were not always documented as notified following a resident incident. (Link to 1.2.4.3). Interview with the manager and three family members confirms that family are kept informed. Resident meetings occur six monthly and family are invited to this and the nurse manager has an open-door policy that she is able to describe.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b relatives stated that they are informed when their family members health status changes.

D11.3 The information pack is available in large print and this can be read to residents.

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: PA Low

Evidence:

The service has complaints management policies and procedures in place.

D13.3h. A complaints procedure is provided to residents and their family within the information pack at entry.

Complaint forms are available at the entrance to the building and the complaint process is in a format that is readily understood and accessible to residents/family/whanau.

All three residents interviewed and three of three family members interviewed confirm they are aware of the complaints process and they would make a complaint to the manager if necessary. The previous audit found that there is a complaints folder but no complaints register in place, this has since been addressed.

This audit evidenced that although complaints have been followed up and addressed, there is no formal acknowledgement of complaints or reply to complainants and this is an area for improvement.

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: PA Low

Evidence:

There is a documented complaints process which is provided to residents and families. Complaint forms are easily accessible. There is evidence that complaints are responded to.

Finding:

There is no formal acknowledgement of complaints or formal reply and closure of complaints for the complaints on file.

Corrective Action:

Ensure that complaints are formally acknowledged according to the policy

Timeframe (days): 30 (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:

Roseanne rest home provides care for up to 16 rest home residents. At the time of the audit there were 16 residents.

The service has documented strategic plan 2014. The quality and risk plan is documented as part of the recently purchased quality and risk programme. The quality and risk plan is currently in the process of being personalised for Roseanne House.

There is a documented review of the previous year's business with new quality and business goals quantifiable and this is an improvement on the previous audit.

Performance is monitored through a quality and risk management programme that includes an internal audit programme. Communication and reports against day to day information's and quality out comes is achieved through six weekly quality meetings, six weekly health and safety meetings and three monthly staff meetings.

The owner/ manager is a registered nurse who owns the facility. She has extensive experience in rest home care and has owned the service since 2010. She has worked at the facility since 2004.

ARC, D17.3di (rest home): The owner/manager attends at least eight hours a year training relevant to requirements.

The four caregivers and one enrolled nurse interviewed state that they receive good support from the owner/manager who is able to provide advice at any time.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The service is implementing the recently purchased quality improvement plan. 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. The service has in place a range of policies and procedures to support service delivery.

Quality data is collected and evaluated and used for quality improvement. Key components of the quality system link to service delivery.

There is a documented audit schedule in place, however not all audits are completed according to the schedule and this is an area for improvement. The previous audit found corrective actions were not well documented against identified issues. This continues to be an area for improvement.

There are (six weekly) quality meeting that includes discussion about clinical indicators including Incidents, infection control, restraint, audit results complaints and other operational matters.

Staff meetings (three monthly) document discussion of new policies, cultural care, documentation, and care of residents including strategies to improve care.

Resident/family meetings are documented as well as three monthly newsletters.

D19.3: There is an H&S and risk management programme in place including policies to guide practice and six weekly health and safety meetings.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

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: PA Low

Evidence:

There is a quality and risk plan that includes an audit schedule. Audit outcomes are documented as discussed in six weekly quality meetings.

Finding:

A review of the audit schedule and audits evidences that audits are not always undertaken. The previous audit finding of corrective action not always documented remains a finding

Corrective Action:

Ensure corrective audits are undertaken according to the schedule and action plans are developed when service shortfalls are identified.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Incidents/accidents are investigated and a log of incidents occurs monthly.

There is a discussion of incidents/accidents in six weekly quality meeting and health and safety meetings.

D19.3c Discussions with the nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

Seven incident forms reviewed six were resident related. Three of six document post incident follow-up by the nurse manager and three of six document that family have been informed- these are identified as areas for improvement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

There is documented incident and accident process. Quality and health and safety meeting document comprehensive discussion of incidents and accidents. Four caregivers and an EN stated that they are kept informed regarding adverse events and the service is proactive with following problems and issues up. Three family members interviewed stated that the service always keeps them informed.

Finding:

Three of six resident related incident forms do not document family communication and three of six resident related incident forms do not document follow-up and review by an RN.

Corrective Action:

Ensure that family communication is documented following an incident and RN review is documented following an incident.

Timeframe (days): 30 (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:

Roseanne House employs 15 staff. Five staff files reviewed; all have a signed job description and employment contract. This is an improvement on the previous audit. Two of the files were for new staff, both have documented reference checks. This is an improvement on the previous audit. The two new staff also have a documented orientation currently in progress. This is also an improvement on the previous audit.

An annual in-service education programme is in place. The annual training plan covers a range of subjects and attendance at these is recorded on staff records. The training programme is comprehensive and includes; Treaty of Waitangi and cultural training (April and May 2014), management of challenging behaviour (May 2014). This is an improvement on the previous audit.

Discussions with four caregivers and the enrolled nurse and a review of documentation demonstrates a commitment to the education of staff that is implemented into practice. All staff have current performance appraisals.

First aid training has been provided and there is a first aider on each shift.

D17.7d: There are implemented competencies for staff related to medication with all relevant caregivers.

The nurse manager, the owner/manager, the enrolled nurse and the GP have current practicing certificates.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service continues to have a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

The registered nurse manager is on site at least 35 hours per week and is on call at all times. Caregivers do the laundry and dedicated staff do cleaning duties.

Staff turnover is low. Four caregivers and the enrolled nurse interviewed stated that there is adequate staffing to manage their workload on any shift.

The GP was interviewed and confirmed that staffing is appropriate to meet the needs of residents.

Three of three residents and three of three family members interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly.

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 electronic resident records could not all be accessed on the day of the audit. This audit was able to access all resident files.

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Prior to entry, potential residents have a needs assessment completed by the needs assessment and co-ordination service, to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. The service has introduced a new Admission Agreement since the previous audit. However this has only been provided to new residents.

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

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

Attainment and Risk: PA Low

Evidence:

New admission agreements comply with a)-k) of the ARC contract.

Finding:

Only new resident have been provided with the new agreement.

Corrective Action:

Ensure that all resident have a copy of the new admission agreement to sign.

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

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

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

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

Attainment and Risk: FA

Evidence:

Roseanne House provides rest home level care for up to 16 residents. On the day of audit the service was full with 16 residents.

D.16.2, 3, and 4: The five resident files sampled identified that the nurse manager completes an initial support plan within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and support plan.

The services uses interRAI assessments and the care plan format generated through a linked care plan generation computer process. The care plans were all individualised and comprehensive. All five resident files sampled identified that the long-term care plan is developed within three weeks. There is documented evidence of multidisciplinary team reviews (MDT) held six monthly. The RN amends the long term care plan to reflect on-going changes as part of the review process. Allied health professionals involved in the residents care are linked to the long term care plan review as relevant. All five resident files sampled included evidence of resident/relative input into the initial assessment, care plan and reviews.

D16.5e: All five resident files reviewed identified that the general practitioner had seen the resident within two working days. There is evidence of the GP reviews at least three monthly.

Four caregivers and the enrolled nurse describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes are maintained on every shift by caregivers or more often if there are any changes.

Tracer Methodology;

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The previous audit identified behaviours that challenge and anxiety were not documented well in care plans. This has been addressed since the previous audit. All care plans are documented well and reflect the interRAI assessment.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

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: PA Low

Evidence:

Overall, the care plans are completed comprehensively, the RN uses the care plan format linked to the InterRAI process. All care plans have been individualised by the RN manager and reflect the care and support needed by each resident. Three residents interviewed state their needs are being met. Three relatives interviewed state their relatives receive care within a timely manner, the care provided is of very high standard and they are kept informed of any health changes.

D18.3 and 4 Dressing supplies are available for use. Contenance 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. Contenance management in-services and wound management in-service have been provided.

The service is introducing a new wound care template following the purchase of the new quality and risk system. There are currently four residents (five wounds) being treated. The resident with two pressure areas has the care and support (including evaluation) of these wounds documented well through progress notes. The wounds show improvement over time. There is documented input from a specialist for these wounds.

One surgical wound and one skin care have a wound assessment, a plan of care and documented evaluations. One Skin tear has no formal assessment there is a management plan and evaluation.

The documentation of wound care is identified as an area for improvement.

Pain assessments are completed on admission as part of the interRAI process. The management of pain is managed well throughout the five resident files reviewed.

Falls prevention strategies are identified, documented and implemented.

Resident's weights are recorded on admission and monthly thereafter with all five resident files documenting good weight management.

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. Residents and families were able to confirm this observation.

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: PA Low

Evidence:

The service is in the process of implementing new wound care plan formats. One surgical wound and one skin tear documented the use of this new format. Wound documentation for two pressure sores is documented will but not on the new tool

Finding:

Two pressure sores have no formal wound assessment documented and one skin tear has no formal assessment documented

Corrective Action:

Continue to fully implement the new wound care templates and ensure that all wounds have a formal assessment, and management plan

Timeframe (days): 30 (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: PA Low

Evidence:

The service continues to provide activities for the residents. There is an activity officer at Roseanne retirement home who works 2.5 hours per day, either morning or afternoon, and is responsible for the planning and delivery of the activities programme five days a week.

The activities officer is currently enrolling on the diversional therapy (DT) course. Activities are provided in the lounge/dining area and one on one input in residents' rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly.

Roseanne Retirement Home has its own van for transporting residents. Outings occur weekly. The activities officer described that an evaluation of individual resident's participation in outings is completed for each trip, to ensure that residents have enjoyed the outing and are able to give feedback.

The programme includes networking within the community with social clubs, churches and schools. There is a range of activities offered that reflect the resident needs. Participation in all activities is voluntary.

Residents meetings occur six monthly. These evidenced residents were able to make suggestions regarding the activities programme and that these were acted on.

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: PA Low

Evidence:

A review of five resident files documented that three of five have a personalised activity plan. There is an overall activity plan in place for all residents and three resident interviewed stated the activities were enjoyable

Finding:

Two of five resident files reviewed did not have a documented individualised activity plan. Of the three residents with an individualised activity plan, one was not sufficiently documented to provide activity guidelines to staff.

Corrective Action:

Ensure that all residents have an individualised activity plan that reflects their recreation needs.

Timeframe (days): 60 (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:

Care plans are documented very well and include six monthly review and evaluation by the registered nurse /manager,

There is at least a three monthly review by the medical practitioner.

D16.4a Care plans are reviewed and evaluated by the nurse manager or owner/manager six monthly or when changes to care occur as sighted in five of five care plans sampled.

There are short term support needs plans to focus on acute and short-term issues. Staff are informed of any changes to resident needs at handover between shifts. Changes to the long term care plan are made as required and at the six monthly review if required.

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:

Medication policies align with accepted guidelines. Medications are stored in a locked cupboard at the nurses' station. There are currently no self-medicating. The service uses individual Robotics medication packs. These are delivered four weekly. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by the nurse manager or owner/ manager who is a registered nurse, a verification form is signed to state that medications have been checked against the medication charts and any pharmacy errors recorded and fed back to the supplying pharmacy. Staff sign for the administration of medications on medication signing sheet. The medication folder reviewed includes a list of those staff who were medication competent at the front of the folder. Competency tests are completed annually and also if there is a medication administration error. Specimen signatures are recorded on each medication signing chart.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Signing sheets correspond to instructions on the medication chart.

D16.5.e.i.2; All ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. The previous short falls around checking the expiry dates of medications and ensuring the GP documents the date that medications are prescribed have been rectified.

This audit evidenced improvements required around staff signing for medication on administration and two signature for all controlled drug medication.

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:

Medication are stored safely, and staff who administer medication have all completed a medication competency. Medicine policies and procedures are in place.

Finding:

The medication charts and the controlled drug medication book are reviewed. There is one instance in the controlled drug book with only one staff signature. There is one medication chart where a staff member has not signed for administration of regular medications

Corrective Action:

Ensure there are two staff signatures for all controlled drug medications. Ensure that staff sign for all medication on administration.

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

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

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

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:

Roseanne House continues to provide appropriate kitchen and meal services. There is a dietitian review of the menu dated May 2013. Three residents and three family members said the meals are very good.

The service employs two cooks and all food is cooked on site. Both cooks have completed food safety training. There is a four weekly rotating winter and summer menu.

A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily.

The residents have a dietary profile developed on admission which identifies dietary requirements and likes and dislikes and this is completed by the cooks. The dietary profile is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook. Special diets being catered for at present are diabetic diets.

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:

Reactive and preventative maintenance occurs. One of the two owners is the maintenance person and he described his role and the facilities maintenance programme at interview. Fire equipment is checked by an external provider (records sighted). The building holds a current warrant of fitness which expires 01 November 2014. Electrical equipment is checked annually. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet. The corridors are carpeted. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained. The garden area has furniture and umbrellas provide shade.

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: PA Low

Evidence:

There are restraint management policies and procedures in place including the use and management of enablers

The Restraint Minimisation Manual identifies that enablers are voluntary and the least restrictive option. There is one resident with an enabler currently in use at Roseanne House. Challenging behaviour and restraint training has been provided to staff.

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: PA Low

Evidence:

There is one resident with an enabler that is documented in the residents care plan.

Finding:

There is no documented review of the resident and the enabler.

Corrective Action:

Ensure that all residents with enablers have six monthly review of the enabler as per policy

Timeframe (days): 90 (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 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The previous audit documented that an annual review of the infection control (IC) programme could not be located. This audit was able to evidence an annual review of the IC programme.

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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 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:

Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at quality and health and safety/ 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.

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.)*