# Waverley Aged Care Limited

## Current Status: 29 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

Waverley House provides care for up to 20 residents who require rest home care, and there were 20 residents on the day of this audit.

The owner is the manager and she is supported by a registered nurse. Residents and family interviews and consumer satisfaction survey results show satisfaction with services provided.

Two of five shortfalls identified at the previous certification audit have been addressed. Improvements continue to be required around implementation of the quality and the risk management system and timely assessment of residents.

This audit identified two high risk findings around implementation of medication management system and timely documentation of service provisions and obtaining an approval from the local need assessment service coordination team before residents enter to the service, particularly for residents requiring higher level of care.

Further improvements are required by the service around implementation of the quality and risk management system, care plan interventions and evaluations, performance appraisals, and a dietition input to the menu.

## Audit Summary as at 29 August 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 29 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 29 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 29 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 medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 29 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 29 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 29 August 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## Introduction

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

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

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

## Audit Report

|  |  |
| --- | --- |
| **Legal entity name:** | Waverley Aged Care Limited |
| **Certificate name:** | Waverley Aged Care Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Waverley House Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 29 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:** | 20 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **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** | XXXXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 8 | Total audit hours off site | 7 | Total audit hours | 15 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 6 | 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) | 18 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed |  |

## Declaration

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

Dated

## Executive Summary of Audit

**General Overview**

Waverley House provides care for up to 20 residents who require rest home care, and there were 20 residents on the day of this audit.

The owner is the manager and she is supported by a registered nurse. Residents and family interviews and consumer satisfaction survey results show satisfaction with services provided.

Two of five shortfalls identified at the previous certification audit have been addressed. Improvements continue to be required around implementation of the quality and the risk management system and timely assessment of residents.

This audit identified two high risk findings around implementation of medication management system and timely documentation of service provisions and obtaining an approval from the local need assessment service coordination team before residents enter to the service, particularly for residents requiring higher level of care.

Further improvements are required by the service around implementation of the quality and risk management system, care plan interventions and evaluations, performance appraisals, and a dietition input to the menu.

**Outcome 1.1: Consumer Rights**

Policies are implemented to support open disclosure in communication with residents and families.

Family members are informed in a timely manner when their family members health status changes. There is a complaints register and complaints are documented and managed.

**Outcome 1.2: Organisational Management**

Waverley House has a quality and risk management plan but this is not fully implemented. Resident satisfaction and food satisfaction surveys are completed in 2014 but and evaluation of survey outcomes are not completed. This was an area for improvement required in the previous audit but it has not been addressed yet. The monthly quality/staff meetings occur and there are regular resident meetings.

There is a documented rationale for determining staffing levels and skill mixes. Staff interview confirms that there is sufficient and appropriate coverage for the effective delivery of care and support. Document review confirms increased staffing hours due to increase in acuity of residents.

There are human resource policies including recruitment, selection, orientation and staff training and development. There is an implemented orientation programme and an in-service training programme covering relevant aspects of care and support. Improvements required for this audit are relating to performance appraisals of staff.

**Outcome 1.3: Continuum of Service Delivery**

Each stage of the assessment, planning, and provision of care and review is undertaken by the registered nurse. Family are notified of any changes in resident's condition and this is documented in the resident’s file. Document review evidenced referral letters to specialists and other health professionals. Progress notes are documented by the caregivers and the registered nurse, and are comprehensive. Handovers between shifts occur and it promotes continuity of service delivery. There are appropriate links developed with other services including the local DHB and the local Hospice. The results of family interviews and consumer surveys confirm satisfaction with the service.

The activity programme is developed and coordinated by a diversional therapist who is employed for 22 hours a week. The program provides a sufficient range of planned activities to maintain resident’s strengths and interests. Due to the gated facility policy, residents need staff assistance to leave the facility. Interviews with the diversional therapist confirm that she facilitates guided walks and outings ensuring that resident’s rights to access out door areas, and the community is provided.

There are medication policies and procedures that cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation. Waverley House uses a robotic medication management system. Controlled medications are checked weekly and this is an improvement since the previous audit.

There is a small but functional kitchen and two cooks are employed on a 'four days on-four days off' roster. A dietary profile is completed on admission by the registered nurse. Additional snacks are available for residents when required. Residents are offered fluids throughout the day. Residents' files sampled demonstrate monitoring of individual resident's weight. There is a rotating four weekly seasonal menu, however there is an improvement required around dietitian input.

This audit identified two high risk findings around implementation of medication management system and timely documentation of service provisions and obtaining an approval from the local need assessment service coordination team before residents enter to the service, particularly for residents requiring higher level of care. Further improvements are required around care plan interventions and evaluations.

**Outcome 1.4: Safe and Appropriate Environment**

Waverley House has a current building warrant of fitness.

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

The policies and procedures include definitions, processes of restraint and use of enablers. The registered nurse is the restraint coordinator. On the day of audit, there are no residents using restraint or enabler. Discussions with three caregivers and the registered nurse confirmed that use of enabler is voluntary and least restrictive option. Staff received training around restraint minimisation and enablers.

**Outcome 3: Infection Prevention and Control**

The infection control nurse is the registered nurse and she is responsible for surveillance of infections. Infection control training is provided annually for staff. The registered nurse completes a monthly infection summary, which is discussed at quality and staff meetings. The infection control surveillance programme is implemented.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 2 | 2 | 2 | 0 |
| **Criteria** | 0 | 32 | 0 | 2 | 4 | 2 | 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 | 61 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Policy review dates are ranging from 2010-2012 and there is no process implemented to ensure that policies are regularly reviewed. This remains an improvement required from the certification audit. | Ensure that polices are reviewed and updated at regular intervals. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | There is an internal audit schedule for 2014 and internal audits have not been completed at all. A consumer survey was conducted in 2014 and 14 residents were responded. However, a survey evaluation has not been conducted for follow up and identification of corrective actions. This remains a required improvement from the previous auditor. Survey results are also not communicated to the residents or families. | Ensure that the internal audit schedule is implemented, results are evaluated. Survey results are communicated to participants. | 90 |
| 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 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | Five files (one RN and four caregivers) reviewed showed that there is no performance appraisal completed for the RN and two out of four caregivers. | Ensure that the RN and the caregivers have annual performance appraisals. | 180 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA High |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA High | Each stage of service provision is undertaken by the RN. Five resident’s files are reviewed and demonstrated the following shortfalls; 1) one resident was admitted XXXXXXXX  2) There is also another resident who is receiving respite care. This resident does not have admission documentation completed on entry to the service including an initial assessment, care plan and consent forms. Medication chart is also not signed by the GP and the medication reconciliation showed a medication error (wrong time of administration of a drug). | Ensure that initial assessment and care planning is completed within 24 hours of admission and ensure that the local NASC team approval is obtained prior entry to the service particularly residents requiring higher level care. | 7 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | D16.4a Care plan evaluations are not completed six monthly and this is evidenced in one of the five files reviewed. Two residents were not due for reviewed and two files had completed care plan evaluations. | Ensure that care plan evaluations are completed at least six monthly. | 90 |
| 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 High |  |  |  |
| 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 High | 10 medication charts are reviewed:  a) four out of 10 medication charts reviewed had medication crossed over but not signed by the prescriber.  b) on one chart, an antibiotic was charted three times a day but on two occasions it was given twice a day only.  c) on one chart, one drug dose was changed but the time of administration of the medication was not recorded.  d) One drug was stopped but it was still in the robotic roll and staff continued to administer it.  e) There is a ‘temporary medication change‘ form in which the RN transcribes frequency of PRN medications. Such as, PRN XXXXXX was instructed to be administered twice a day as a regular medication. This happened on two occasions. In another incident, a medication was transcribed to be given every second day.  f) Two signing sheets had signing gaps.  g) On one chart, three monthly medication review was not signed by the GP.  h) On one chart, dose of insulin was changed. The prescriber crossed over the dose and re-wrote the new dose next to it. . Staff continued to administer the new dose at bed time. The RN stated that according to discussions with the GP, this was a reduction of insulin dose however the time of administration of XXXXX did not changed.  i) Four drugs were expired. Two of those expired in 2012. The other two drugs expired in June and January 2014. One drug was currently not in use XXXX but kept in the drug cabinet.  k). On one chart (respite care resident) – a medication was prescribed to be given at nocte but administered at tea time. This was transcribed onto the medication chart which is not signed by the GP. The medication was dispensed on to the robotic rolls as a tea time medication | 1) Transcribing should cease immediately. 2) Expired drugs and discontinued drugs should be returned to supplying pharmacy. 3) Medications to be administered as prescribed. 4) Discontinued medications to be signed by the prescriber and change of dose should be re-written. 5) Ensure that medication administration system complies with the medication care guides for residential aged care. | 7 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Six staff files reviewed showed that one staff member had current medication competency dated January 2014. One staff member had completed the medication competency but it was not dated and four staff had medication competencies completed in 2012. Staff medication administration competencies are not current. Since the draft report, the provider has advised that all staff have now completed their medication competencies, and have commenced an On-line training course facilitated by the RN, with the current topic as medications. | Ensure that staff administer medication have current medication competency. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.1 | Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | Dietitian input to the menu has not been obtained since 2008. | Ensure that a dietitian input to the menu is obtained. | 180 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All family members are informed on entry to the service that Waverley House is a secure, gated facility. Resident files reviewed included signed consent forms and resident needs assessments that identified the service is appropriate for the resident.

Ten incident and accident files reviewed identified that seven had family notification recorded. Three forms did not have family notification included in the incident and accident form but review of resident file including progress notes and the family communication sheets provided evidence recording of family notification. On interview, the manager and the registered nurse (RN) ascertain the processes that are in place to support family being kept informed.

Five residents and two family members interviewed confirmed that the admission process and admission agreements were discussed with them and they were provided with adequate information on entry. Resident meetings occur three monthly.

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 Two relatives stated that they are always informed when their family members health status changes.

D11.3 The information pack is available in large print.

##### 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 complaints policy, and complaints procedure is provided to resident/relatives at entry to the service. Complaint forms are available at the entrance to the building. –Three caregivers, a diversional therapist (DT), the registered nurse (RN), and the cook interviewed are aware of the complaints process and to whom they should direct complaints.

There is a complaints register that includes one complaint for 2013 and resolution is dated 5 July 2013. On interview the manager was aware of her responsibilities around complaint management and stated that they have not received any complaints in 2014. Discussion with five residents and two relatives confirmed they were provided with information on complaints and they both did not had any concerns to bring it to the management’s attention. An e mail was kept in the register that includes mainly compliments and some thoughts around supervision of a resident. The manager stated that this is kept in the complaint folder but the family did not want the manager to consider it as a complaint. She stated that the matter was discussed with the family member and staff are aware of that.

##### 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:**

Waverley House is managed by an experienced manager/owner who has many years of experience in managing aged care facilities. She is supported by a registered nurse who works 20 hours per week from Monday to Friday. The RN provides on call after hours cover for clinical emergencies. During a temporary absence of the owner/manager, the facility is managed by the RN. The manager advised that there is also a memorandum of understanding with another local rest home manager who is available for support.

Waverley House has a current business plan and quality risk management plan. The quality programme is managed by the owner/manager with assistance from the registered nurse. The service has an annual planner/schedule which includes audits, meetings and education.

D15.3d: The manager has maintained at least eight hours of professional development activities annually related to managing a rest home.

##### 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 Moderate

**Evidence:**

Waverley House has a business plan and quality risk management plan. Progress with the quality plan is monitored through the monthly staff/quality meetings. Quality data is discussed at these meetings. Minutes from staff /quality meetings are available for staff to read.

Discussions with the RN and three caregivers confirm their involvement in the quality programme. Resident satisfaction survey is completed in 2014 and survey results show satisfaction with services provided. Food services survey is also completed in 2014 which shows satisfaction with meal services.

There is an internal audit schedule completed for 2013 and includes (but is not limited to): cleaning, laundry, food service, admission procedures, infection control, care plans, complaints, medication management, personal privacy and safety, continence, cultural safety and spiritual beliefs, wound management, staff training and informed consent. However, 2014 internal audit schedule has not been implemented. An improvement is required.

Three caregivers interviewed confirm that they are informed of new care plan interventions, short term care planning, incident accidents via handovers and meetings. There is evidence of documented management of non-compliance issues.

Waverley House has a health and safety management system and security, and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There are infection control programme and corresponding policies. There are restraint minimisation policy, and health and safety policies and procedures that are implemented.

The annual staff training programme is implemented. Records of staff attendance are maintained.

Waverley House collects information on resident incidents and accidents as well as staff incidents/accidents. Accident/incident forms are commenced by caregivers and given to the RN who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the manager who completes any additional follow up as required.

An improvement is required around review of policy and procedures.

D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g Falls prevention strategies such as falls risk assessment, walking aids, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.

##### 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:** PA Moderate

**Evidence:**

Waverley House has policies and procedures that are implemented. Since the previous audit, the secure gated facility policy has been reviewed. The manager stated that the support is obtained from the local DHB in review of this policy.

**Finding:**

Policy review dates are ranging from 2010-2012 and there is no process implemented to ensure that policies are regularly reviewed. This remains an improvement required from the certification audit.

**Corrective Action:**

Ensure that polices are reviewed and updated at regular intervals.

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

##### Criterion 1.2.3.5 (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:** PA Moderate

**Evidence:**

Resident satisfaction survey and the food satisfaction surveys are completed in 2014.

**Finding:**

There is an internal audit schedule for 2014 and internal audits have not been completed at all. A consumer survey was conducted in 2014 and 14 residents were responded. However, a survey evaluation has not been conducted for follow up and identification of corrective actions. This remains a required improvement from the previous auditor. Survey results are also not communicated to the residents or families.

**Corrective Action:**

Ensure that the internal audit schedule is implemented, results are evaluated. Survey results are communicated to participants.

**Timeframe (days):** 90 *(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:**

Incident/accidents are documented. Reporting of incidents/accidents occur, and are monitored. This was evident in the sample group of 10 incident forms and five residents’ files. Incidence and accident information was also recorded in progress notes. Incident analysis is performed monthly by the RN. Service short falls are managed with staffing rosters and the availability of on call staff (the RN and the manager).

Ten incident reports for June and July 2014 were reviewed and include six falls with minor or non-injury, one medication error and three skin tears. Family notification documented in either the incident form or family notification sheet. Following a medication error, staff notified the RN and they followed the RN’s instructions.

The RN, the manager or caregivers contacts the family. Three caregivers and two families interviewed confirmed that families are contacted if there are any problems.

D19.3d . Discussions with the manager, and the RN confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

##### 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:**

Waverley House has a process for validating the qualifications of registered health professionals. The current practicing certificate for the RN is kept in her file.

There is an orientation programme in place and three caregivers interviewed could describe the orientation training. Completed orientation records are evident in the staff files.

There is a documented education plan. Training completed includes (but is not limited to), privacy, skin care, fire training, hazard and emergency management, diabetes, continence management, respiratory diseases, elder abuse, restraint minimisation and enablers, complaints management, infection control, wound management, challenging behaviour and dementia,- walking in another’s shoes- and mental health of older person.

Interview with the manager and the RN confirmed that Waverley House had developed links with the local DHB to ensure that staff employed have access to training and support that is not available within the service.

An improvement required around staff performance appraisals.

The local DHB has requested further information relating to following areas:

1- Caregivers training hours- 2014 training plan is implemented. Caregivers training records are also kept and exceed eight hours a year.

2- RN training records- Training records of the RN is sighted. In 2014, following trainings are completed: 1) January 2014-steps towards positive wellbeing in dementia, walking in another’s shoes, four hours, 2) April 2014- Assessment- clinical supervision and continuing nursing education, seven hours, 3) May 2014 – wound management workshop- one and half hours, 4) June 2014 –Advanced care planning , infection control, medication related to increased falls risk, subcutaneous fluids. six hours, 5) August 2014 – Wound study day- six hours. Training records also show a series of training that offered by the HBDHB. The RN completed 32.5 hours of training in 2013.

3- Medication competencies- Staff who administer medication complete medication competencies yearly. Six staff files reviewed showed that one staff member had current medication competency dated January 2014. One staff member had completed competency but it was not dated and four staff had medication competency completed in 2012. See CAR.1.3.12.3.

##### 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:** PA Moderate

**Evidence:**

There is a performance appraisal process in place. Caregivers training records are also kept and exceed eight hours a year.

**Finding:**

Five files (one RN and four caregivers) reviewed showed that there is no performance appraisal completed for the RN and two out of four caregivers.

**Corrective Action:**

Ensure that the RN and the caregivers have annual performance appraisals.

**Timeframe (days):** 180 *(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 rationale that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides minimum staffing cover. The manager and registered nurse provide an after-hours on call service to support staff. (link 1.3.3.3)

Interview with five residents and two relatives confirmed that the residents care needs are met. Staff interviewed stated that they have been very busy but they are able to complete their duties.

The roster is as follows: Occupancy 20 residents.

The manager works 08.00-16.30hrs Monday-Thursday.

The RN works for 20 hours per week Monday to Friday. She is available on call.

Diversional therapist works 10 -16.00 four days a week.

Cook works 8-13.00 and there is a dedicated cleaning and laundry staff.

Waverley House contracts with allied health professionals on an as required basis.

Caregivers - am shift

1x 07.00-15.00hrs 1x 07.00-15.00hrs - The manager stated that the second shift is used to be 09-13.00 and the most recently has been changed to 7.00-15.00 due to increased acuity of residents.

Caregivers -pm shift 1x-15.00-23.00hrs, 1x15.00-21.00hrs.

Caregivers Nocte -1x 23.00-07.00hrs.

##### 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:** PA High

**Evidence:**

Each stage of the assessment, planning, and provision of care and review is undertaken by the RN who is competent to perform her duties. Although she does not have a formal peer support or mentoring, she has access to a nurse specialist from the local DHB and the local hospice. The RN and the manager confirmed this on interview. An improvement is required around establishment of formal peer support and mentoring. See CAR. 1.2.7.5.

The RN’s responsibility is to conduct the initial assessment and initial care plan on admission to the service, and to develop the long term care plan within three weeks. Initial assessments and care planning and short term care planning are completed on admission in three out of five files reviewed.

In four out of five files, residents care plans are evaluated and interventions updated six monthly or more frequently as the resident needs changes. Evaluation includes consultation with the resident, caregivers, resident`s family and/or whānau. Progress notes are documented by the caregivers and the RN, and are comprehensive. One file reviewed was overdue for care plan evaluations. See CAR-1.3.8.3.

GP notes reviewed evidenced three monthly reviews by the GP or more often as required. Handovers between shifts occur and it promotes continuity of service. Three caregivers interviewed confirmed that they are encouraged to read the progress notes and care plans of each resident. Family/whānau involvement is maintained and sighted in all five residents' files.

Tracer methodology:

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

D16.2, 3, 4: Timeframes of service delivery is not met. See CAR-1.3.3.3.

D16.5e: Five resident files reviewed identified that the GP had seen the resident within two working days. Residents are reviewed by the GP on a monthly basis or when residents are stable assessed and reviewed by the GP three monthly.

##### 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:** PA High

**Evidence:**

Required corrective action around re assessment of residents who require secure environment for safety has been addressed. The policy has been reviewed and the consent for the acceptance of a locked facility forms are dated and signed on entry to the facility.

**Finding:**

Each stage of service provision is undertaken by the RN. Five resident’s files are reviewed and demonstrated the following shortfalls; 1) one resident was admitted XXXXX There was no initial assessment or care plan completed on admission and to date. Discussions with the manager and the RN confirmed that NASC assessment is not completed and there is no documentation relating to the resident’s placement in the service. The manager stated they have informed the local NASC team, but there is no documented evidence of this. Beginning of the day, staff are concerned that the resident was in pain and the RN notified the hospice. Later in the day, the resident was noted to be comfortable. The RN stated that the hospice had no vacancy and there is no hospital level care bed available locally.

Staffing level is appropriate for the rest home level care, but there is only one night staff on duty and the RN is on call. Caregiving staff do not administer controlled drugs and not all staff who administer medication had current medication administration competency. Staff ‘s capability to provide pain assessment and timely pain medication is quite limited. There was noted to be one other resident requiring two person assistance and the RN stated that hospital level care assessment was requested for this resident. Documentation is sighted.

2) There is also another resident who is receiving respite care and awaiting a bed in another facility. This resident does not have admission documentation completed on entry to the service including an initial assessment, care plan and consent forms. Medication chart is also not signed by the GP and the medication reconciliation showed a medication error (wrong time of administration of a drug).

**Corrective Action:**

Ensure that initial assessment and care planning is completed within 24 hours of admission and ensure that the local NASC team approval is obtained prior entry to the service particularly residents requiring higher level care.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** FA

**Evidence:**

Two out of five files reviewed showed that care plans are not documented, and these include initial assessment, care planning and admission documentation. See CAR-1.3.3.3.

In three files out of five, care plans are developed and implemented. Interventions in these care plans are appropriate and reflective of current good practice.

The care plans of one resident has not been evaluated within the last six months. See Car 1.3.8.3.

There are appropriate links developed with other services including the local DHB and the local Hospice. Two family members and five residents and consumer survey results confirm satisfaction with the service, and family members stated that resident’s needs were being appropriately met. Discussions with the visiting hospice RN confirmed that she was happy with the care provided by the service, and stated that there are no vacant beds in the hospice. However, document review shows lack of documented evidence around interventions that are consistent with meeting the residents’ assessed needs or desired outcomes. Waverley House provides hospital level care without documented intervention. An improvement is required in this area. See Car 1.3.3.3.

D18.3 and 4- Dressing supplies are available and a treatment room is stocked for use.

Continence products are available, and resident files include continence assessments and continence products identified for day use, night use, and other management.

Continence management in-service (22 April 2013) and wound management in-service (18 November 2013) have been provided.

The RN interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse through the DHB as needed.

An internal audit of continence management was last conducted on May-2013.

The local DHB has requested further information around wound management.

Wound assessment and wound management plans are in place for four residents. The four wounds include two foot wounds and two minor wounds. All had current assessment and wound management plan in place. On interview the RN stated that there were no bed sores and all wounds are healing.

One resident was assessed for hospital level care, and a special grant was given to the Waverley House by the local DHB to continue with their services. This resident died prior to the surveillance audit. Discussions with the RN confirmed that the local DHB is responsive to individual needs of residents and supports the service with a specialist nurse input.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The activity programme is developed and coordinated by a DT who is employed 22 hours a week. The program provides a sufficient range of planned activities to maintain resident’s strengths and interests.

A range of activities are available and these include the involvement of the residents into the community. The programme reflects resident’s interest and they have choice in their level of participation. Activities include (but are not limited to): (a) outings and supervised walks, (b) exercise programmes, (c) music, (d) crafts, (e) supervised walks, (f) cooking, (g) reading, (g) games, and (h) entertainment. Resident’s social history and their preferred activities are identified on admission and these are documented in the resident’s file.

Activities are planned monthly and a copy of the activities plan is displayed on the notice board at the reception/entrance area and in the lounge.

D16.5d Individual activity plans are reviewed when care plans are reviewed.

Two relatives interviewed are satisfied by the activities programme and stated that it is appropriate for their relatives.

Due to the gated facility policy, residents need staff assistance to leave the facility. Interviews with the DT confirm that she facilitates guided walks and outings ensuring that resident’s rights to access outdoor areas and the community is provided. The DT stated that she is well supported by the staff and the management.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

##### 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:**

Two out of five residents files sampled showed that care plans are evaluated by the RN six monthly or earlier if needed. Two of the files were the most recent admissions and were not due for review. One residents was due for care plan evaluation in February 2014 and has not been completed yet. An improvement is required. There is at least a three monthly review by the medical practitioner for medically stable residents. Staff (RN, caregivers and the DT) and family interview confirmed that evaluations are conducted by the RN with input from the resident, family, care staff, DT and general practitioner. On the day of audit, GP was not available for interview.

Changes in health status are documented in progress notes and by use of short term care plans. Short term care plans are used widely by the RN. For example, one resident requiring reduced dose of insulin had short term care plan. Another resident with infection and wound also had short term care plans.

Family are notified of any changes in resident's condition and this is documented in the resident’s file. Document review evidenced referral letters to specialists and other health professionals.

Two relatives confirm that they are involved in the review of their relatives care.

D16.3c: Three out of five files reviewed showed that all initial short term care plans were developed and documented by the RN within three weeks of admission and care is evaluated by the RN over the initial three weeks of the resident's admission. A long term care plan is developed within three weeks of admission. Two files reviewed had no initial care planning at all. See Car 1.3.3.3.

D16.3k Short term care plans are in use for changes in health status e.g. infections, wounds, skin tears, changes in health status.

##### 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:** PA Low

**Evidence:**

Two resident’s files out of five had documented care plan evaluations that are consumer focused and indicate degree of achievements against interventions.

**Finding:**

D16.4a Care plan evaluations are not completed six monthly and this is evidenced in one of the five files reviewed. Two residents were not due for reviewed and two files had completed care plan evaluations.

**Corrective Action:**

Ensure that care plan evaluations are completed at least six monthly.

**Timeframe (days):** 90 *(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 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. This is evidenced in one resident who has been referred for hospital level care assessment. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. D16.4c; The service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care. However one resident was admitted for palliative care but there is lack of documented evidence around notification to the needs assessment service coordination agency/ Options Hawke’s Bay. See CAR-1.3.3.3.

D 20.1 Discussions with the RN identified that the service has access to the needs assessment service co-ordination agency, primary care and district nursing, specialist nurse advisors from the DHB, specialist medical services (including the older persons mental health and allied health service, Hawke's Bay DHB) and laboratory services, and the local hospice.

Waverley House continued to be operated as a locked facility and there is digital lock on the front door. Since the previous audit, the policy has been updated. The policy is discussed with the EPOA or resident on admission and a consent is obtained. Eight files are reviewed to test if all consent are signed and dated. This was evidenced in all eight files. On the day of the audit, visitors and family members are able to use the access code and leave and enter the building as they wished. The auditor did not observed any resident who made an attempt to go out of the building. Residents are regularly taken for a walk with staff assistance. Review of these files and the staff interview confirmed that there are no residents reside in Waverley House that required re assessment due to increase needs for a secure environment for safety. Therefore required corrective action from the previous audit has been addressed.

##### Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

**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 High

**Evidence:**

Medication policies and procedures cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation. Waverley House uses a robotic medication management system. Robotic rolls are delivered monthly in fortnightly rolls. The RN reconciles medicines on delivery, and the pharmacist is informed of any discrepancies. Medication charts have photographic identification. All care staff are required to be competent to administer medicines due to the need to have an effective roster and the RN oversees this process. Medicines are stored in a locked storage area in a corridor opposite the RN's office. Controlled drugs are stored in a locked safe in a locked cupboard within that locked area. Controlled medications are checked weekly and this is an improvement since the previous audit. .Any medications requiring refrigeration are kept in a separate covered box in the fridge in the kitchen. Fridge temperature recordings are documented. On the day of audit there are no residents self-administering medicines. The audit identified several issues that are considered high risk.

D16.5.e.i.2; GPs review residents three monthly or more frequently and sign their respective medication chart. This is evidenced in nine out of 10 medication charts. See CAR- 1.3.12.1.

##### 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 High

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. Waverley House uses a robotic system and the medications are checked on arrival from the pharmacy by the RN. Any mistakes by the pharmacy are regarded as an incident and reported back to the Pharmacy. Medicines are stored in a locked storage area in a corridor opposite the RN's office. Controlled drugs are stored in a locked safe in a locked cupboard within that locked area. Controlled medications are checked weekly and this is an improvement since the previous audit. Any medications requiring refrigeration are kept in a separate covered box in the fridge in the kitchen. Fridge temperature monitoring occurs. Medication charts record prescribed medications by residents’ general practitioner; these are kept in the medication folders. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and prn medication. Allergies are identified in residents’ medication charts.

**Finding:**

10 medication charts are reviewed:

a) four out of 10 medication charts reviewed had medication crossed over but not signed by the prescriber.

b) on one chart, an antibiotic was charted three times a day but on two occasions it was given twice a day only.

c) on one chart, one drug dose was changed but the time of administration of the medication was not recorded.

d) One drug was stopped XXXXX but it was still in the robotic roll and staff continued to administer it.

e) There is a ‘temporary medication change‘ form in which the RN transcribes frequency of PRN medications. Such as, PRN paracetamol was instructed to be administered twice a day as a regular medication. This happened on two occasions. In another incident, laxol was transcribed to be given every second day”.

f) Two signing sheets had signing gaps.

g) On one chart, three monthly medication review was not signed by the GP.

h) On one chart, dose of insulin XXXXX was changed. The prescriber crossed over the dose and re-wrote the new dose next to it. 15 units XXXXX were charted at bed time. It was crossed over and the new dose was re-written as 12 units at dinner time. Staff continued to administer the new dose at bed time. The RN stated that according to discussions with the GP, this was a reduction of insulin dose however the time of administration of insulin did not changed.

i) Four drugs were expired. Two of those expired in 2012. The other two drugs expired in June and January 2014. One drug was currently not in use XXXXX but kept in the drug cabinet.

k). On one chart (respite care resident) – a medication XXXXXX was prescribed to be given at nocte but administered at tea time. This was transcribed onto the medication chart which is not signed by the GP. The medication was dispensed on to the robotic rolls as a tea time medication

**Corrective Action:**

1) Transcribing should cease immediately. 2) Expired drugs and discontinued drugs should be returned to supplying pharmacy. 3) Medications to be administered as prescribed. 4) Discontinued medications to be signed by the prescriber and change of dose should be re-written. 5) Ensure that medication administration system complies with the medication care guides for residential aged care.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

All care staff are required to be competent to administer medicines. Staff who administer medication complete medication competencies yearly. Six staff files reviewed showed that one staff member had current medication competency dated January 2014.

**Finding:**

Six staff files reviewed showed that one staff member had current medication competency dated January 2014. One staff member had completed the medication competency but it was not dated and four staff had medication competencies completed in 2012. Staff medication administration competencies are not current. Since the draft report, the provider has advised that all staff have now completed their medication competencies, and have commenced an On-line training course facilitated by the RN, with the current topic as medications.

**Corrective Action:**

Ensure that staff administer medication have current medication competency.

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

##### Criterion 1.3.12.5 (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:** PA Low

**Evidence:**

Food service policies and procedures are appropriate to the service setting. A dietary profile is completed on admission by the RN. Two cooks and caregivers are advised of resident’s likes and dislikes and any special dietary needs or allergies. There is a small but functional kitchen and two cooks are employed 07.30-13.00 hrs daily on a 'four days on-four days off' roster.

Additional snacks are available for residents when required. Residents are offered fluids throughout the day. Residents' files sampled demonstrate monitoring of individual resident's weight. Food in the kitchen and storage areas are dated, labelled and rotated. Food in the fridges and freezers are stored correctly, dated and covered. Fridge and freezer temperatures are checked and recorded. There is a rotating four weekly seasonal menu. There has been no dietitian input in their menu since 2008.

Two relatives and five residents confirm that they are satisfied with the meal service. Lunch meals sighted during the audit are observed to be well presented. Food services audit is completed in 2014 July and shows satisfaction with meal services.

D19.2 Staff have been trained in safe food handling.

##### 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:** PA Low

**Evidence:**

There is a rotating four weekly seasonal menu.

**Finding:**

Dietitian input to the menu has not been obtained since 2008.

**Corrective Action:**

Ensure that a dietitian input to the menu is obtained.

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

Waverley House has a current Warrant of fitness which expires on 1 November 2014. Waverley House is a totally secure environment, with a key pad lock on the front door. The keypad is interfaced with the fire alarm system, so that in the event of a fire alarm activation the door lock will automatically be opened and fire exits electronically controlled.

##### 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.)*

# 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:**

The policies and procedures include definitions, processes of restraint and use of enablers. The RN is the restraint coordinator. On the day of audit, there are no residents using restraint or enabler. Discussions with three caregivers and the RN confirmed that use of enabler is voluntary and least restrictive option. Staff received training around restraint minimisation and enablers in March 2013.

Waverley House continued to be operated as a locked facility and there is a digital lock on the front door. Since the previous audit, the policy has been updated. The policy is discussed with the EPOA or resident on admission and a consent is obtained. Eight files are reviewed to test if all consent are signed and dated. This was evidenced in all eight files. On the day of the audit, visitors and family members are able to use the access code and leave and enter the building as they wished. The auditor did not observed any resident who made an attempt to go out of the building. Residents are regularly taken for a walk with staff assistance. Review of these files and the staff interview confirmed that there are no residents reside in Waverley House that required re assessment due to increase needs for a secure environment for safety.

##### 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:**

RN is the infection control coordinator. She collates the surveillance data and documents them on a monthly basis. The surveillance results are communicated to staff and any relevant points are communicated to residents and families.

Three caregivers and a cook interviewed stated infection prevention and control information is communicated at the staff meetings and during handovers.

Compliance with infection control practices is measured through the internal audit system and the results of surveillance data and observation. Outcomes and actions are discussed at the quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible by the visiting specialists/related health professionals if required.

Hand washing audits are completed five times in 2013. Staff received training around infection control in November 2013.

##### 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.)*