# Mayfair Lifecare (2008) Limited

## Current Status: 28 January 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

Mayfair Lifecare (2008) Ltd provides rest home and hospital level care for up to 88 residents. On the day of the audit, there were 87 residents, 65 rest home and 22 hospital. The service is managed by an experienced managing director (registered nurse). Staff interviewed and documentation reviewed identified that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided. The service continues to implement a system of continuous quality improvement and residents and family spoken to advised that the staff are caring and attentive.

The service has addressed the one shortfall from the previous partial provisional audit relating to recruitment of staff for providing hospital level care.

This audit identified no improvements required.

## Audit Summary as at 28 January 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 28 January 2014

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

### Organisational Management as at 28 January 2014

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

### Continuum of Service Delivery as at 28 January 2014

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

### Safe and Appropriate Environment as at 28 January 2014

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

### Restraint Minimisation and Safe Practice as at 28 January 2014

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

### Infection Prevention and Control as at 28 January 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Mayfair Lifecare (2008) Limited |
| **Certificate name:** | Mayfair Lifecare (2008) Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Mayfair Lifecare | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 28 January 2014 | **End date:** | 28 January 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 87 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 16 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 81 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, 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:

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| --- | --- | --- |
| 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 Monday, 24 February 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Mayfair Lifecare (2008) Ltd provides rest home and hospital level care for up to 88 residents. On the day of the audit, there were 87 residents, 65 rest home and 22 hospital. The service is managed by an experienced managing director (registered nurse). Staff interviewed and documentation reviewed identified that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided. The service continues to implement a system of continuous quality improvement and residents and family spoken to advised that the staff are caring and attentive. The service has addressed the one shortfall from the previous partial provisional audit relating to recruitment of staff for providing hospital level care.  This audit identified no improvements required. |

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| **Outcome 1.1: Consumer Rights** |
| The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are able to residents and family. Information relating to the Health and Disability Commissioner and advocacy service with contact details are also provided. Information on how to make a complaint and the complaints process are included in the admission booklet. Complaints are actively managed. |

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| **Outcome 1.2: Organisational Management** |
| Mayfair Lifecare has a current business and quality plan to support quality and risk management. Quality information is gathered from internal audits, incidents and accidents, feedback from residents, family and staff. Data is collected and collated to provide opportunities for improvement. Corrective actions are implemented. Resident/relative surveys are undertaken annually. Adverse events are investigated and opportunities for improvement are actioned. Staff requirements are determined using a skill mix process and acuity levels and documented. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents. The service has a documented training plan. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Care plans are developed by the registered nurses who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Care plans are evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Residents and family members interviewed state that they are kept involved and informed about the resident's care. The medication management system includes medication policy and procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents’ general practitioner at least three monthly. A range of activities are available and residents provide feedback on the programme. Mayfair Lifecare has food policies/procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. Dietitian input is obtained, residents' food preferences are identified and this includes any particular dietary preferences or needs. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Mayfair Lifecare has a current building certificate that expires on 1 August 2014. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has two hospital residents assessed as requiring restraint as falls prevention measures and no residents with enablers. There is a restraint register and an enabler’s register. Staff receive training in restraint minimisation and challenging behaviour management. Competencies are also completed. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control nurse (clinical manager) at Mayfair Lifecare completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or the registered nurses and a copy of any incident relating to individual residents is included in the clinical file. A communication sheet records that families are informed following general practitioner (GP) review, incidents or accidents or if there is a change in resident condition (confirmed by four relatives interviewed).   Interviews with the clinical manager and two registered nurses all stated that they are to record contact with family/whanau in resident files. Incident forms have a section to indicate if family/whanau have been informed of an incident/accident.  Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in the manager’s office and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet.  Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet. 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 admission agreement and admission booklet. Residents (seven) and relatives (four) interviewed, confirmed they are kept fully informed. The admission booklet is available in large print and can be read to residents if required. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints process and forms for completion are available within the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. The managing director maintains the records of all complaints that are processed as evidenced by the six resident related complaints received for 2013. Details of the management of the complaints is recorded including letters of follow up and response. Complaints are discussed at the monthly quality meetings, and at the general staff meetings. A complaints procedure is provided to residents within the information pack at entry. Seven residents and four family members interviewed were aware of the complaints process and advised that management is approachable and responsive to any issues or areas of concern. |

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

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

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

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

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Mayfair Lifecare is owned and operated by a group of shareholders with day to day management provided by a managing director. The managing director is a registered nurse and maintains an annual practicing certificate. She is experienced in aged care and has been manager of Mayfair Lifecare for over 13 years. The managing director reports to the company directors on areas relating to health and safety, quality, achievement with key performance indicators, repairs and maintenance, wages, rostering and staffing, and occupancy. The service has a business plan for 2014 which includes a current quality and risk management programme, occupancy, staffing and service levels. A quality management system is implemented which includes gathering data and information to provide opportunities for quality improvement. The organisation has a mission statement and documented philosophy of care. The managing director has attended in excess of eight hours of professional development in the past 12 months relating to managing the facility and includes attending aged care conference, attending internal and external meetings and maintaining nursing professional development. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Mayfair Lifecare has a current quality programme for 2014 which includes the mission and philosophy of service, a quality policy statement and objectives. The quality programme objectives consists of strategies, document control, education plan, internal meeting planner, service review - clinical and non-clinical indicators, consumer feedback, corrective actions and a risk management plan. The risk management plan includes human resource management, resident clinical care management, infection control, environment and equipment safety management, and information and business management. Hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.    Progress with the quality programme and risk management plan is monitored through the monthly quality improvement/infection control meetings, various staff meetings, three monthly health and safety meetings, and a comprehensive annual review is conducted (last conducted March 2013). The annual review involves review of the diversional therapy programme, incident trend and analysis, complaints, corrective actions, infection control programme, service monitoring and service risk. A quality manager is contracted and attends the facility twice a month to review progress. The monthly quality/infection control meeting agenda includes (but is not limited to): previous meetings minutes, review of clinical and non-clinical indicators, quality manager’s report, internal audits, complaints, education, quality initiatives, policy and document review and progress with corrective actions. Minutes from the quality meetings are available for staff to read in the staff room (sighted for December 2013). A full team staff meeting is held three monthly (sighted for September 2013) and agenda items include progress with key performance indicators, education, audits, gardens, maintenance, infection surveillance, resident care, new staff, rosters, documentation, housekeeping, laundry and general issues. All meeting minutes have a corrective action format and include actions to achieve compliance where relevant. This, together with staff training, demonstrates Mayfair Lifecare’s on-going commitment to continuous quality improvement. Discussions with registered nurses and caregivers confirm their involvement in the quality programme. Folders in the nurse’s stations are maintained with meeting minutes, quality and audit outcomes and a monthly newsletter for staff also keeps them informed of quality matters. Resident/relative meetings take place two monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for September 2013. Other meetings include registered nurse meeting, kitchen, cleaners, night staff and rest home and hospital staff meetings.  There is an internal audit schedule completed for 2013 and a plan in place for 2014. It includes (but is not limited to): informed consent, complaints management, incident management, care plans, personal cares, wound management, pain management, medicine management, waste management, housekeeping, laundry, restraint use, infection control, kitchen and safe food management. There is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A register of corrective actions is maintained and signed off when completed by the quality manager. For each corrective action, a corrective action request is developed to document what is required to meet the shortfall. These are sent through to staff to action and signed off by the registered nurses and quality manager when completed. Corrective actions are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions.    The service has a health and safety management system and this includes the identification of a health and safety officer. 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 is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. The quality committee is responsible for development and review of policies and procedures and includes the managing director, clinical manager, and quality manager. 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. There are procedures to guide staff in managing clinical and non-clinical emergencies and implemented risk management, health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, increased supervision and monitoring and sensor mats if required. The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by caregivers and given to the registered nurses who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the clinical manager and managing director who completes any additional follow up. The managing director collates and analyses data to identify trends. Results are discussed with staff through the monthly quality meetings, and three monthly staff meetings.  A resident survey (2013) and a relative’s survey (2013) is conducted annually. Residents and families are surveyed on nursing care, allied health, food service, housekeeping, personal rights, laundry and recreation programme. The surveys reviewed evidence that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via the facility newsletter and meetings. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, at the three monthly staff meetings and three health and safety meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and four family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incident forms for November 2013 were reviewed and involved four residents - one hospital resident with five falls; one hospital resident with 14 incidents of challenging behaviours; one rest home residents with two falls; and one rest home resident with a skin tear. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the clinical manager and managing director. Referral to general practitioner has been instigated as required. Medication errors are also reported. A monthly incident trend analysis and annual incident trend analysis is conducted with reviews and summaries is compiled by the quality manager and managing director with subsequent analysis and investigations. Analysis occurs around falls, skin tears, challenging behaviours, environment and equipment, medications, infections, complaints and acuity levels of residents. Incidents and accidents are reported in progress notes and communication with family regarding incidents is also recorded. Staff have received education regarding open disclosure, incident reporting and communication with families. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses, and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (one clinical manager, one registered nurse, one enrolled nurse and three caregivers). Advised that reference checks are completed before employment is offered as evidenced in one recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Nine caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in six of six staff files reviewed.  Discussion with the managing director, clinical manager, two registered nurses, three enrolled nurses and nine caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and a plan for 2014. The annual training programme exceeds eight hours annually. Caregivers have completed either the national certificate in care of the elderly or are working towards completion. The managing director, clinical manager and registered nursing staff attend external training including conferences, seminars and sessions provided by the local DHB.  Education provided in 2013 includes but not limited to: medications, manual handling, chemical safety, infection control, code of consumer rights, restraint, continence, safe food handling, and nutrition. Fire evacuation drill last conducted in September 2013. Annual appraisals are conducted for all staff as evidenced in six of six files reviewed. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Human resource management policies includes a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home and hospital residents. A minimum of four staff are rostered on at any one time with a registered nurse on every shift. Acuity levels of residents are monitored each month and staffing levels are adjusted accordingly. Roster includes the managing director (RN) 40 hours per week, clinical manager 40 hour per week, a clinical coordinator in the rest home and in the hospital, registered and enrolled nurses on each shift and caregiving staff who work short and long shifts in each area. Staffing levels have been increase with the provision of hospital level care and the service now has a full complement of staff to safely meet the needs of the resident cohort. The service has made improvements in this area from previous partial provisional audit. The service also employs laundry staff, cleaning staff, cook and kitchen hands and a maintenance person and gardeners. Interviews with the managing director, clinical manager, two registered nurses, three enrolled nurses, nine caregivers, seven residents and four family members identify that staffing is adequate to meet the needs of residents. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service completes an initial assessment on the day of admission and completes an initial care plan within 48 hours. Care plans are developed by registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are developed in consultation with residents and family/whanau where appropriate. Seven residents (three hospital and four rest home) and four family members (three rest homes and one hospital) confirmed their involvement in the care planning process.   D16.2, 3, 4: The six files reviewed identified an assessment was completed within 24 hours and in five of six residents files, the lifestyle support plan was completed within three weeks (one recent admission). There is documented evidence that the lifestyle support plans were reviewed by a RN and amended when current health changes. Five of six care plans evidenced evaluations completed at least three monthly.  D16.5e: All six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in four rest home and one hospital resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly and in one hospital files the resident is to be reviewed monthly. Documentation of GP visits were evident that reviews were occurring in the time frames documented.  A range of assessment tools where completed in all six resident files on admission and completed at least six monthly including (but not limited to); falls risk assessment, pressure area risk assessment, pain, challenging behaviours, continence, and nutrition.  The resident mobility transfer plan is included the monthly review with notes by the physiotherapist. Mayfair retirement village contracts a physiotherapist for two hours per week. Caregivers complete lifestyle notes at the end of each shift. There is an appropriate hand-over briefing between shifts that staff were able to fully describe.  GP interviewed stated that he is confident with the service and states that staff contact him with appropriate information (including observations) in a timely fashion in regards to resident concerns and altered health status.  Tracer Methodology;  Hospital: Resident *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  Rest Home: *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.

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with care givers, registered nurses, residents, families, general practitioner and management. Care plans are goal orientated and reviewed at six monthly intervals and more frequently if required. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.  Short term care plans are in use for changes in health status. Nine caregivers (all work across the service) interviewed stated that they have all the equipment referred to in the care plans and necessary to provide care, including wheelchairs, hoist, lifting belts, continence supplies, dressing supplies and any miscellaneous items. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Continence management in-service (August 2013) and wound management in-service have been provided (2012 and planned for 2014).  There was a wound care assessment and management plan in place for twelve residents with wounds. No wounds are related to pressure. All wounds have wound assessments, management plans, evaluation and progress documented. There was documentation evident of the service referring wound care for external input from Nurse Maude services.  Two registered nurses (one hospital and one rest home) and two enrolled nurses (rest home) interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Staff are provided with current training practises and this involves external in-service opportunities. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A diversional therapist works 32 hours per week - Monday to Friday and has been in the role for two years. Three activities assistants also work part time and provide an additional 37 hours per week. Care staff were observed assisting with activities during audit. A large purposed built room (the Gallery) is available for activities to take place and is well equipped. The diversional therapy team meets monthly to plan and review the programme. There is a resident social profile and activity assessment completed and an activity plan is developed and reviewed at least three monthly. The facility activity plan is developed on a monthly basis with input from residents. A variety of activities are provided that also reflect normal patterns of life. The programme is monitored through regular meetings and surveys. A record of attendance is kept and progress notes written. Residents and families interviewed indicated they found the programme enjoyable and interesting.  D16.5d Six resident files reviewed identified that an individual activity plan is in place. The files reviewed identified that the individual activity plan is developed based on a resident social profile and activity assessment and has been reviewed at activities plan review.  A comprehensive resident social profile is completed on admission. The activities plan has resident focused goals and programme activities with three monthly evaluations and attendance records for individual residents. The programme of activities is broad and involves maintaining the resident’s interests along with community involvement when possible. Residents are encouraged to participate in activities in the community. A facility van is available for outings. Activities plan is posted on the hallway notice boards (four), in each resident's room and is available in large print. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care plans are evaluated at least six monthly for all residents and if there is a change in the health status of the resident. The GP reviews resident’s medical condition and medication charts at least every three months.   ARC D16.3c: All initial care plans are evaluated by the registered nurse in the rest home and hospital, or clinical coordinator (EN) with registered nurse over sight in the Charlotte Jane studio and apartments wing. The long term care plan is developed within three weeks of admission. All six resident files evidence that care plans are evaluated at least six monthly. There is evidence that the overall care plans have been evaluated indicating the degree of achievement of goals and objectives. There is a section on the care plan for the clinical nurse manager or registered nurse to sign when the review is completed. Clinical nurse manager, registered nurse, enrolled nurses, caregivers, resident and family are involved at the time of care plan review.  Short term care plans are used for issues such as wounds, infections or short term changes to care. |

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

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

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP.  Signing sheets are in place for packed medication, short term, and prn medication.  The service has adequate information and supervises the self-administration of medicines. Two residents currently self-medicate, medications are securely stored in resident’s room. The registered nurse and general practitioner complete a three monthly competency assessment and there is resident self-administration signing sheet.  The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents’ medication charts and resident files on the front page. There is a medication error/mishap assessment form and procedure in place. There is a staff signature identification sheet in the front of the medication folders.  There is a two controlled drug registers, with weekly stock takes by the RN.  All Staff performing medication administration receive training on medicine management policies and procedures.  D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Mayfair Lifecare has a well-run food service that is managed by a head cook and supported by part time cooks and kitchen hands. All are trained in food safety. A four week winter and summer menu is reviewed by a dietitian and regular food safety compliance audits are conducted. Residents and families interviewed were complimentary of the food provided. The service is able to meet the dietary and food service requirements of rest home and hospital level residents.  Nutritional assessments have been conducted in all six files reviewed. Dietary information is documented in the care plan and a dietary form is provided for kitchen staff. Likes and dislikes are recorded on the initial care plan. A large white board in the kitchen records resident requirements. The service is able to respond to residents with additional or modified dietary requirements. Special equipment and utensils for residents who require assistance is available. Staff are available to assist residents with food and fluid intake.  Resident’s weight is monitored regularly. Those residents with weight issues have a short term care plan in place. There is evidence of residents receiving supplements and clinical nurse manager advised that a dietitian is available for advice and support if required.  Daily temperature checks of fridge and freezer are maintained as well as hot and cold food temperatures. The walk-in chiller, freezer and pantry are clean and tidy with no food stored on the floor. Food is covered, labelled and dated. D19.2 Staff have been trained in safe food handling. The food programme at Mayfair incorporates infection control and health and safety information and guidelines. |

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

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

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

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

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

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

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

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

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a current building warrant of fitness which expires 1 August 2014. |

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

All buildings, plant, and equipment comply with legislation.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. There are two hospital residents assessed as requiring restraint in the form of bedrails and these are used as falls preventions measures only. There are no residents using enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. The staff interviewed are familiar with this. Restraint/enabler use is discussed at quality improvement meetings, and at staff meetings. Restraint use audit conducted June 2013. Staff received training around restraint minimisation and safe practice in April and August 2013. Management of challenging behaviours education was provided as part of this session. Restraint questionnaires and competency are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. |

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

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

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality improvement meetings, and three monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the managing director. The clinical manager is the designated infection control nurse and has attended infection control training in 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.

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

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

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

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