

Parata Anglican Charitable Trust

Current Status: 14 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

Parata Home is certified to provide rest home level care for up to 26 residents. On the day of the audit there were 26 residents. The service is owned and governed by the Parata Anglican Charitable Trust. The manager is an enrolled nurse and has been in the role since 1993, she is supported by a registered nurse.

This audit identified that 17 of the 22 shortfalls identified at the previous audit have been addressed. These are around strategic planning, policies, corrective actions, accident/incident management, initial risk assessments and care plans, family and resident involvement in assessments, care planning and evaluations, activity plan reviews, evaluations, short term care plans, controlled drug management, restraint management and the restraint register. Improvements continue to be required around staff training and performance appraisals, the admission agreement, enduring power of attorney documentation, timeliness of assessments and weight recordings, care planning, hot water temperatures and electrical checks.

This audit identified further areas requiring improvement around having suitable registered nursing cover, employment contracts and human resource files, blood sugar monitoring, timeframes for wound reviews, aspects of medication management, the paint surface on one fridge, hoist servicing and calibration of medical equipment.

Audit Summary as at 14 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

Indicator	Description	Definition
	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 14 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.
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Organisational Management as at 14 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.
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Continuum of Service Delivery as at 14 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.
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Safe and Appropriate Environment as at 14 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint Minimisation and Safe Practice as at 14 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.
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Infection Prevention and Control as at 14 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.
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HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Parata Anglican Charitable Trust		
Certificate name:	Parata Anglican Charitable Trust		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Parata Residence		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 14 August 2014	End date:	14 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:			26

Audit Team

Lead Auditor	XXXXXXX	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	XXXXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	11	Total audit hours	27
Number of residents interviewed	6	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	30	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			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:

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, 17 November 2014

Executive Summary of Audit

General Overview

Parata Home is certified to provide rest home level care for up to 26 residents. On the day of the audit there were 26 residents. The service is owned and governed by the Parata Anglican Charitable Trust. The manager is an enrolled nurse and has been in the role since 1993. She is supported by a registered nurse who was on leave at the time of the audit.

This audit identified that 17 of the 22 shortfalls identified at the previous audit have been addressed. These are around strategic planning, policies, corrective actions, accident/incident management, initial risk assessments and care plans, family and resident involvement in assessments, care planning and evaluations, activity plan reviews, evaluations, short term care plans, controlled drug management, restraint management and the restraint register. Improvements continue to be required around staff training and performance appraisals, the admission agreement, enduring power of attorney documentation, timeliness of assessments and weight recordings, care planning, hot water temperatures and electrical checks.

This audit identified further areas requiring improvement around having suitable registered nursing cover, employment contracts and human resource files, blood sugar monitoring, timeframes for wound reviews, aspects of medication management, the paint surface on one fridge, hoist servicing and calibration of medical equipment.

Outcome 1.1: Consumer Rights

Policies and procedures are in place relating to open disclosure, complaints, and accident / incidents. Residents and family report that they were welcomed on entry and were given time and explanation about services and procedures. They are kept informed following an adverse event or if there is any change in the resident's condition. Interpreter services are available if needed.

Residents and their family/whanau are provided with information on the complaints process on admission. Staff are aware of the complaints process. A complaints/compliments folder is maintained. No complaints have been lodged in the past three years. Residents and family members are aware of the complaints procedure and how to access complaints forms. They report that they are comfortable speaking with the manager if they have a concern.

Outcome 1.2: Organisational Management

Parata Rest Home is owned and governed by the Parata Anglican Charitable Trust. A governing trust board provides overarching governance to the service with support provided by a board trustee/administrator.

The service has a current quality improvement plan and a risk management plan that reflects the strategic direction for the service. This is an improvement from the previous audit. Accidents and incidents; complaints, infections; and the use of restraint is monitored each month. A range of internal audits relating to rest home level of care are conducted throughout the year. Quality improvement activities are identified from audits,

meetings, staff and resident feedback and incidents/accidents. Where issues arise, corrective actions are developed. This is an improvement from the previous audit, staff are kept informed.

Policies and procedures are reviewed with a document control process in place. The medication policy links to the Medicine Care Guidelines for Residential Care 2011. This is an improvement from the previous audit. The restraint policy is due to be renewed. This is a previous finding that remains.

The service has a health and safety management system. A safe environment is provided. Emergency plans ensure appropriate response in an emergency. Accidents and incidents are managed appropriately. This is an improvement from the previous audit.

An orientation programme is in place that provides new staff with relevant information for safe work practice. The auditor was unable to sight the registered nurse's staff file and four of five employment contracts. This is a required improvement. Education and training in 2014 includes Careerforce training for six caregivers. General staff education has not yet commenced in 2014 with the exception of medication management and emergency procedures. This is a required improvement. Staff certificates in safe chemical handling training and safe food handling is a previous finding that remains. Annual performance appraisals are up-to-date for the four staff files reviewed including staff who have been employed for longer than one year. This is an improvement from the previous audit.

A staffing policy is in place. A registered nurse (RN) is rostered to work approximately 30 hours per week. Shared call is undertaken by the RN, enrolled nurse (EN)/manager and the assistant manager. The assistant manager has let her EN practising certificate lapse. This is a required improvement. The RN was on leave during this audit. The manager is replacing the registered nurse during her leave due to her inability to find a replacement RN. This is also a required improvement. Interviews with caregivers, residents and family members identify that staffing is adequate to meet the needs of residents.

Outcome 1.3: Continuum of Service Delivery

The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. There is improvement required around the admission agreement and enduring power of attorney documentation. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. Communication with family is well documented. All residents have an individualised care plan. These are reviewed six monthly and updated as needs change. There are improvements required around blood sugar monitoring and timeframes for wound reviews.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans that identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly.

A medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Caregivers administer medications. Staff responsible for medicine management have been assessed as competent. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are no

residents who are self-medicating. There are improvements required expired medications, medication charts and safe administration of medication.

All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services. The menu is currently under review by a dietitian. There is an improvement required around the paint surface on one fridge.

Outcome 1.4: Safe and Appropriate Environment

The service has a current building warrant of fitness and preventative and reactive maintenance occur. A safe environment is provided that is suitable to the needs of the residents. Improvements are required around hot water monitoring, electrical testing, calibration of medical equipment and servicing of the hoist.

Outcome 2: Restraint Minimisation and Safe Practice

The service currently has two residents with bedrails in use as enablers, there are no restraints currently in place. The manager and caregivers are familiar with the definitions of an enabler and a restraint. Previously identified shortfalls included no restraint register, no restraint assessment form for one resident, no evidence of consent for one resident using restraint, and no evidence of monitoring restraint use. These shortfalls have now been addressed. Required improvements remain around restraint policies and procedures and restraint education and training.

Outcome 3: Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	4	5	0	0
Criteria	0	38	0	6	4	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	27
Criteria	0	0	0	0	0	0	0	53

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 Low			
HDS(C)S.2008	Criterion 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.	PA Low	The restraint policy and procedure, which had previously been archived is now back in the policy and procedure manual but has not been reviewed. This previously identified improvement remains (link to previous finding 2.2.1.1).	The restraint policy and procedure requires review.	180
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate			

HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	One senior staff members file was not available for sighting. Employment contracts were sighted in only one of the five staff files selected for review. The manager reports that the senior staff members file is held with the staff member who was on leave during the audit, and that employment contracts are held at the home of one of the management team.	Ensure that all human resource files and signed employment contracts are readily available for sighting.	180
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 Low	The registered nurse is meeting monthly with six caregivers for their Careerforce training. The other staff have not attended education and training for 2014 with the exception of fire and emergency planning and medication competencies. Staff do not hold certificates in safe chemical handling (kitchen staff and cleaners) and food handling (kitchen staff) although an in-service on these two topics was provided.	Ensure staff attend a minimum of eight hours annually of in-service education. Ensure staff that handle chemicals and work in the kitchen hold certificates in food safety and chemical training.	90
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	There is not currently no access to a registered nurse 24 hours per day, seven days per week.	The service is required to have access to an RN 24 hours a day seven days a week.	90
HDS(C)S.2008	Standard 1.3.1: Entry To Services	Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	PA Low			

HDS(C)S.2008	Criterion 1.3.1.4	Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.	PA Low	(i) The admission agreement does not align with a) to k) of the ARC contract (D13.3). (ii) Of the 16 residents with EPAO's, eight do not have these in the resident file.	(i) Ensure that admission agreement aligns with the requirements of the ARC contract. (ii) Ensure that EPOA documents are kept in the resident file.	90
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 Moderate			
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 Moderate	(ii) Two residents requiring weekly blood sugar readings do not have these completed every week. (ii) Two of six resident files (one of who has low weight) have not had their weight recorded monthly. (iii) Neither of the two current wounds have timeframes for review documented. One of six residents had not had the continence assessment reviewed six monthly and another has an undated continence assessment. One resident with challenging behaviour has not had the assessment reviewed since June 2013. Three of six resident files sampled have no date on the nursing assessment. One resident has a pressure risk assessment that is not dated.	Ensure that services are provided in appropriate timeframes (weights and blood sugar levels) and that the timeframes specified in the ARC contract around assessments are followed. Ensure that all wounds have a timeframe documented for the next dressing or review.	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Of the six resident files sampled all have areas of identified need that do not have comprehensive interventions to meet the need. Examples include toileting, pressure area risk, falls risk	Ensure care plan interventions contain enough detail and interventions to guide staff performing care.	90

				management, exercises ordered by the physiotherapist and the need for pureed meat.		
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 Moderate			
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 Moderate	(i) There are expired suppositories and lotion in the utility (treatment) room. (ii) Of 10 medication charts sampled three have occasions when non packaged regular medications have not been signed as administered. (iii) One resident is reported by staff and a family member (interviewed) to have had all her medications stopped by the GP. These were not given for a month (and documented as withheld on the signing sheet). The GP did not cease the medications or document in the medical notes that he was aware the medications had been stopped. This resident was prescribed liquid paracetamol during this time (documented by GP). The signing sheet shows this was administered at lunch, tea and bed time but not at breakfast time. On two occasions the medication was signed for twice although the assistant manager is certain this was a signing error and it was not given twice. Another resident is being administered Spiriva which has not been prescribed on the medication chart. (iv) One medication chart in use has the	(i) Ensure all expired medications are disposed of or returned to the pharmacy. (ii) Ensure medications are administered as prescribed. (iii) Ensure medication charts are accurate and signed (iv) Ensure all home remedies are prescribed by the GP.	60

				PRN medications signed by the GP but none of the regular medications. (v) One resident was recently being administered a home remedy (antibiotic support) supplied by her family that was not charted by the GP (the remedy has since been stopped).		
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 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	One of the fridges in the kitchen has a significant area of damaged paint on the door meaning it can no longer be cleaned effectively.	Ensure the door of the fridge is repaired or replaced.	180
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Moderate	(i) Electrical testing and tagging has not been conducted. (ii) Medical equipment has not been calibrated. (iii) Hot water is tested three monthly but some readings are too high and no corrective action has been taken. (iv) There is no evidence of the hoist having been serviced.	(i) Ensure all electrical equipment is tested and tagged regularly. (ii) Ensure all medical equipment is calibrated according to the manufacturer's specifications. (iii) Ensure hot water temperatures are maintained in a safe range. (iv) Ensure the hoist is serviced annually.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.9: 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:

There is an open disclosure policy, a complaints policy, and an accident/incident policy. Six residents and three family members stated they were welcomed on entry and were given time and explanation about services and procedures. The manager has an open-door policy. Residents and relatives report that they are comfortable speaking with the manager if they have a concern.

The manager reports that resident/relative meetings have been trialled but longer take place due to a lack of interest by the residents.

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 The three family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising. This was evident on all of the accident reports and correlating progress notes reviewed for June and July 2014.

The service has policies and procedures regarding access to interpreter services. Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a complaints policy in place. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance and in each resident room. Staff are aware of the complaints process and to whom they should direct complaints, evidenced in interviews with three of three caregivers. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. No complaints have been received in the past three years. There is a complaints register which is utilised for documenting complaints. Six of six residents and three and three family members advised that they are aware of the complaints procedure and how to access forms. They all report that they are very satisfied with the services that they are receiving. This was further evidenced in the review of 31 residents and relatives satisfaction surveys which were completed in July/August 2014.

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

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:

Parata Rest Home is situated in Gore and is owned and governed by the Parata Anglican Charitable Trust. A governing trust board provides overarching governance to the service with support provided by a board trustee/administrator. The manager of the rest home reports to the administrator who provides the trust board with a two-monthly report. The administrator (a retired accountant) visits the facility daily and manages human resource management and financial management.

Parata Rest Home is certified to provide rest home level care for 26 residents with full occupancy on the day of audit. The service has a current quality improvement plan and a risk management plan for 2014 - 2017. Aims of the plan are: to provide a high standard of quality support that is person-centred, focused, measurable, and affordable; to meet standards and contractual requirements; and for all staff to demonstrate quality improvement awareness. Each aim is followed by a list of objectives, action plans, person(s) responsible and completion dates. This is an improvement from the previous audit.

The quality programme is managed by the manager, and the RN. The quality team incorporates the administrator, the manager, the assistant manager and the registered nurse. The service has an annual planner which includes audits, meetings, education and a policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. .

The manager has been in her role at Parata Rest Home since 1993. She is an enrolled nurse with a current practising certificate. She is replacing the RN while the RN is away on a six week holiday (link to finding 1.2.8.1).

D15.3d: The manager has maintained at least eight hours annually of professional development activities 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 Low

Evidence:

The quality management team meets three-monthly to review progress with the quality improvement and risk management programmes and presents this information in the three-monthly staff meetings. The staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and are posted in the staff room. Minutes include actions to achieve compliance where relevant. Discussions with the manager and three care givers confirm their involvement in the quality programme.

Policies and procedures are in place and evidence updating at review time with the exception of the restraint policy. The restraint policy and procedure, which had previously been archived is now back in the policy and procedure manual but has not been reviewed. This previously identified improvement remains (link to previous finding 2.2.1.1). The content of the medication management policy aligns with current Medicine Care Guides 2011. This is an improvement from the previous audit. There is a document control policy that outlines the system implemented whereby policies and procedures are reviewed.

The service regularly monitors accidents and incidents; complaints, infections; and the use of restraint. Internal audits are conducted and include: workplace inspection, infection control, nursing care, laundry, kitchen, admission standards, code of resident's rights and medication. Data that is collected is collated, trended and used for service improvements. Where issues arise, corrective actions are developed with follow-through completed and resolution documented. This is an identified improvement from the previous audit. Internal audit results and corrective actions are discussed in the three-monthly staff meetings. Audit results and corrective actions are posted in the staff room for staff to read.

The service has a health and safety management system. 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.

D5.4 The service has policies/ procedures to support service delivery. Policies are reviewed annually. The manager and administrator are responsible for policy review.

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 are in place including falls risk assessments, medication reviews, physiotherapy assessments, use of appropriate footwear, correct seating, 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: PA Low

Evidence:

Policies and procedures are in place and evidence dating at review time. The content of the medication management policy aligns with current Medicine Care Guides 2011. This is an improvement from the previous audit. There is a document control policy that outlines the system implemented whereby policies and procedures are reviewed. Documents no longer relevant to the service are removed and archived.

Finding:

The restraint policy and procedure, which had previously been archived is now back in the policy and procedure manual but has not been reviewed. This previously identified improvement remains (link to previous finding 2.2.1.1).

Corrective Action:

The restraint policy and procedure requires review.

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

Criterion 1.2.3.4 (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.

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p>

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a resident accident reporting policy. There is a discussion of accidents/incidents at three-monthly quality/staff meetings. A discussion with the manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. A sample of incident/accident forms were reviewed for July and August 2014. There is evidence of assessment and first aid provided, registered nurse follow up including clinical observations, post fall assessment forms, development of short term care plans and review of risk assessments, review by GP and referral as appropriate. This is an improvement from the previous audit. Accidents and incidents are documented in the residents' progress notes. Note: while the RN has been away on holiday, the manager has been responsible for the investigation and follow-up of accidents and incidents (link to finding 1.2.8.1).

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.

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

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

The staffing levels policy and procedures requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates including the registered nurse, manager and general practitioners are kept. There are human resources (HR) policies including recruitment, orientation, and staff training and development. Five staff files were selected for review (four caregivers and one cleaner). The RN's HR file was not available for sighting. Employment contracts were sighted in only one of the five staff files selected for review. These are required improvements.

An orientation programme is in place that provides new staff with relevant information for safe work practice. All three caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists were evident in all five staff members' files reviewed.

There was an in-service programme for 2013 which has not been carried over to 2014. The registered nurse is meeting monthly with six caregivers for their Careerforce training. The other staff have not attended education and training for 2014 with the exception of fire and emergency planning and medication competencies. This is a required improvement. The manager and registered nurse attend external training including conferences, seminars and sessions provided by the local DHB.

Staff do not hold certificates in safe chemical handling (kitchen staff and cleaners) and food handling (kitchen staff) although an in-service on these two topics was provided. This required improvement remains.

The RN has completed InterRAI training. She is an assessor for Careerforce.

Annual performance appraisals are up-to-date for the four staff files reviewed including staff who have been employed for longer than one year. This is an improvement from the previous audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

There are human resources (HR) policies including recruitment, orientation, and staff training and development. Five staff files were selected for review (four caregivers and one cleaner).

Finding:

One senior staff members file was not available for sighting. Employment contracts were sighted in only one of the five staff files selected for review. The manager reports that the senior staff members file is held with the staff member who was on leave during the audit, and that employment contracts are held at the home of one of the management team.

Corrective Action:

Ensure that all human resource files and signed employment contracts are readily available for sighting.

Timeframe (days): 180 (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 Low

Evidence:

There was an in-service programme for 2013 which has not been carried over to 2014.

The RN has completed InterRAI training. She is an assessor for Careerforce. The manager and registered nurse attend external training including conferences, seminars and sessions provided by the local DHB.

Annual performance appraisals are up-to-date for the four staff files reviewed where the staff have been employed for longer than one year. This is an improvement from the previous audit. Since the draft report the service advised, training in medication competency, informed consent, Treaty of Waitangi and restraint/enablers has been completed. First aid, manual handling and chemical safety will be completed by the end of the year.

Finding

The registered nurse is meeting monthly with six caregivers for their Careerforce training. The other staff have not attended education and training for 2014 with the exception of fire and emergency planning and medication competencies. Staff do not hold certificates in safe chemical handling (kitchen staff and cleaners) and food handling (kitchen staff) although an in-service on these two topics was provided.

Corrective Action:

Ensure staff attend a minimum of eight hours annually of in-service education. Ensure staff that handle chemicals and work in the kitchen hold certificates in food safety and chemical training.

Timeframe (days): 90 *(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: PA Low

Evidence:

The staffing levels policy includes staff rationale and skill mix. Sufficient caregiver staff are rostered on to manage the care requirements of the rest home residents. At least one staff member is rostered on at any one time with one staff on-call. The registered nurse, manager (EN) and assistant manager share the first on call.

Extra staff can be called on for increased resident requirements. Roster includes: manager 40 hours per week, RN 30 hours (average) per week. The morning shift is covered by two caregivers who work a full shift and two care givers who work short shifts. There is also a cleaner, cook and kitchen assistant on the morning shift. The afternoon shift is covered by two full shift care givers and one short shift care giver. There is one care giver on overnight with shared on-call provided.

During this spot surveillance audit, the RN was on a six-week holiday with the manager filling her role. The manager reports that she tried to get an RN replacement but was unsuccessful.

Interviews with three caregivers, six residents and three 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.

Attainment and Risk: PA Low

Evidence:

The staffing levels policy includes staff rationale and skill mix. Sufficient caregiver staff are rostered on to manage the care requirements of the rest home residents. At least one staff member is rostered on at any one time with one staff on-call. The RN is currently on holiday.

Extra staff can be called on for increased resident requirements. Roster includes: manager/EN 40 hours per week, RN 30 hours (average) per week. The morning shift is covered by two care givers who work a full shift and two care givers who work short shifts. There is also a cleaner, cook and kitchen assistant on the morning shift. The afternoon shift is covered by two full shift care givers and one short shift care giver. There is one care giver on overnight with shared on-call provided.

Interviews with three caregivers, six residents and three family members identify that staffing is adequate to meet the needs of residents.

Finding:

There is not currently no access to a registered nurse 24 hours per day, seven days per week.

Corrective Action:

The service is required to have access to an RN 24 hours a day seven days a week.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The previous audit identified that the admission agreement does not align with a) -k) of the ARC contract (D13.3). The admission agreement has been altered since the previous audit but still does not meet contractual requirements. The previous audit also identified that there were no legal documents to support residents' EPOA in two of six resident files sampled. Of the 16 residents with EPOA's, eight continue not to have the documentation available. These areas continue to require improvement. The

previous audit also identified that not all residents had NASC assessments. A review of five files shows all have NASC assessments. This issue has been addressed. Also, following an identified shortfall at the last audit the service information provided to prospective residents has been updated and the issue has been addressed.

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

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

Attainment and Risk: PA Low

Evidence:

The previous audit identified that not all residents had NASC assessments. A review of five files shows all have NASC assessments. This issue has been addressed. Also, following an identified shortfall at the last audit the service information provided to prospective residents has been updated and the issue has been addressed.

Finding:

(i) The admission agreement does not align with a) to k) of the ARC contract (D13.3). (ii) Of the 16 residents with EPAO's, eight do not have these in the resident file.

Corrective Action:

(i) Ensure that admission agreement aligns with the requirements of the ARC contract. (ii) Ensure that EPOA documents are kept in the resident file.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: PA Moderate

Evidence:

D16.2, 3, and 4: The three of five resident files reviewed for the three residents admitted since the previous audit identified that an initial nursing assessment and care plan was completed within 24 hours and these files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes (link 1.2.8.1 re availability of registered nurse). Three of five care plans evidenced evaluations completed at least six monthly. Two residents have not yet been at the service for six months. Activity assessments and the activities care plans have been completed by the activities coordinator. Six residents interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files included family contact records, which were completed in all resident files sampled.

D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review was evidenced as occurring on review of resident's files with acute conditions. The previous audit identified that service provision timeframes for initial care plans and assessments, risk assessments, wound care, informed consent, advanced directives, GP medical reviews and weight are not adhered to. A review of five files indicate timeframes are now adhered to around initial care plans and assessments, informed consent, advanced

directives and GP medical reviews. Improvement continues to be required around documenting timeframes for review of wounds, dating all assessments, six monthly reviews of some assessments, monthly (minimum) weights. Additionally improvement is required around ensuring blood sugar levels are taken within the specified time frame. A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment, b) pressure area risk assessment, c) continence assessment and d) skin assessment. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Five files reviewed identified integration of allied health and a team approach is evident. The general practitioner interviewed reported that the registered nurse and manager consult with him with any concerns regarding residents' health status and she believes the service provided meets resident's needs.

Tracer Methodology:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

D16.2, 3, and 4: The three of five resident files reviewed for the three residents admitted since the previous audit identified that an initial nursing assessment and care plan was completed within 24 hours and these files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes (link 1.2.8.1 re availability of registered nurse). Three of five care plans evidenced evaluations completed at least six monthly. Two residents have not yet been at the service for six months. Activity assessments and the activities care plans have been completed by the activities coordinator. Six residents interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files included family contact records, which were completed in all resident files sampled.

D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review was evidenced as occurring on review of resident's files with acute conditions. The previous audit identified that service provision timeframes for initial care plans and assessments, risk assessments, wound care, informed consent, advanced directives, GP medical reviews and weight are not adhered to. A review of five files indicate timeframes are now adhered to around initial care plans and assessments, informed consent, advanced directives and GP medical reviews.

Finding:

(ii) Two residents requiring weekly blood sugar readings do not have these completed every week. (ii) Two of six resident files (one of who has low weight) have not had their weight recorded monthly. (iii) Neither of the two current wounds have timeframes for review documented.

One of six residents had not had the continence assessment reviewed six monthly and another has an undated continence assessment. One resident with challenging behaviour has not had the assessment reviewed since June 2013. Three of six resident files sampled have no date on the nursing assessment. One resident has a pressure risk assessment that is not dated.

Corrective Action:

Ensure that services are provided in appropriate timeframes (weights and blood sugar levels) and that the timeframes specified in the ARC contract around assessments are followed. Ensure that all wounds have a timeframe documented for the next dressing or review.

Timeframe (days): 90 (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 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

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

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

Attainment and Risk: FA

Evidence: The previous audit identified that initial care plans and risk assessments are not conducted on admission to the facility. A review of five files including three for residents admitted since the last audit shows an initial assessment and basic care plan is completed on the day of admission. Following this a comprehensive nursing assessment, a falls risk assessment, pressure risk assessment, pain assessment and continence assessment and a dietary profile are completed to inform the long term care plan (link 1.3.3). The previous shortfall has been addressed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The previous audit identified that resident files reviewed identified lack of interventions to support the care required to manage the risks identified via the assessment process. A review of five files indicates that while improvement has been made since the previous audit, of the six resident files sampled all have

areas of identified need that do not have comprehensive interventions to meet the need. Examples include toileting, pressure area risk, falls risk management, exercises ordered by the physiotherapist and the need for pureed meat. Improvement continues to be required.

The previous audit also identified that weight is not recorded monthly and referral to dietitian not initiated. Three of the five files sampled have the weight recorded monthly (link 1.3.3.3). No current residents require referral to a dietitian.

Further, the previous audit identified there was no recorded evidence of resident and /or family involvement in assessment, care planning or evaluations of care. The five files reviewed for this audit identify documented family and resident input in the initial assessments, care plans and evaluations. Six residents and three family members interviewed confirm they are involved in assessments, care plans and evaluations. The previous shortfall has been addressed.

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

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

Attainment and Risk: PA Moderate

Evidence:

The previous audit also identified that weight is not recorded monthly and referral to dietitian not initiated. Three of the five files sampled have the weight recorded monthly (link 1.3.3.3). No current residents require referral to a dietitian.

Further, the previous audit identified there was no recorded evidence of resident and /or family involvement in assessment, care planning or evaluations of care. The five files reviewed for this audit identify documented family and resident input in the initial assessments, care plans and evaluations. Six residents and three family members interviewed confirm they are involved in assessments, care plans and evaluations. The previous shortfall has been addressed.

Finding:

Of the six resident files sampled all have areas of identified need that do not have comprehensive interventions to meet the need. Examples include toileting, pressure area risk, falls risk management, exercises ordered by the physiotherapist and the need for pureed meat.

Corrective Action:

Ensure care plan interventions contain enough detail and interventions to guide staff performing care.

Timeframe (days): 90 (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:

Five resident files were reviewed. The three files of residents admitted since the previous audit identified that an initial nursing assessment and care plan was completed within 24 hours and these files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by

the registered nurse and amended when current health changes (link 1.2.8.1). Three of five care plans evidenced evaluations completed at least six monthly. Two residents have not yet been at the service for six months. Activity assessments and the activities care plans have been completed by the activities coordinator. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, the GP and the manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews. The manager is responsible for the education programme (link 1.2.7.5) and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurse. Care delivery is recorded and evaluated by caregivers or the registered nurse in the progress notes at least at least daily (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the registered nurse, assistant manager or manager initiates a review and if required, arranges a GP visit or a specialist referral. The three caregivers, activities coordinator and the manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, a hoist, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Six residents interviewed and three family interviewed were complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for two residents with wounds (one cancerous lesion and one diabetic ulcer). Timeframes for review are not documented (link 1.3.3.3) noting that only the manager, assistant manager or registered nurse (when back from leave) complete dressings so all are aware of when dressing next require review. Neither of the current wounds require specialist input.

The manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

The manager, assistant manager and registered nurse have attended external wound management training.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an activities coordinator at Parata Home who provides a combined programme for residents and day stay clients. She is responsible for the planning and delivery of the activities programme. Activities are primarily provided in the large activities lounge and also in dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the activities care plan and this is reviewed six monthly as part of the care plan review/evaluation. This is an improvement since the previous audit. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. Parata Home has its own van for transportation. Residents interviewed described attending concerts, school music productions, going shopping, lunches and picnics, and shopping. The diversional therapist and activities coordinators have a current first aid certificate.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed 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: FA

Evidence:

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

D16.4a Care plans are reviewed and evaluated by the registered nurse six monthly or when changes to care occur as sighted in three of five care plans sampled. Two residents have not been at the service for six months. A comprehensive evaluation form is completed which documents progress against each domain of the care plan. This is an improvement since the previous audit. There are short term care plans to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the registered nurse or manager (link 1.2.8.1) when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, behaviours and wounds. All short term care plans are evaluated and signed off when the issue is resolved. This is an improvement since the previous audit. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

ARC D16.3c: Three of three initial nursing assessment/care plans were evaluated by an RN within three weeks of admission (two residents admitted prior to the previous audit did not have initial assessments completed on admission).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Medication policies align with accepted guidelines. The medication policy has been updated to remove reference to the registered nurse not requiring a medication competency. This is an improvement since the previous audit. Medications are stored in a locked cupboard the office. There are expired suppositories and lotion in the utility (treatment) room. This is an area requiring improvement. Controlled drugs are stored in a locked safe and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. This is an improvement since the previous audit. The service uses monthly blister packs that are packed by the pharmacy. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by the registered nurse or the manager (an enrolled nurse) and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet. Of 10 medication charts sampled three have occasions when non packaged regular medications have not been signed as administered. This is an area requiring improvement. The other seven administration sheets sampled correlate with prescribed instructions. Indication for use is documented for all PRN medications. The medication folder includes a list of specimen signatures. There are currently no residents self-administering medications.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. One new resident who has been at the service 48 hours does not have a signed medication chart. This is a further area requiring improvement. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. One resident is reported by staff and her daughter (interviewed) to have had all her medications stopped by the GP. These were not given for a month (and documented as withheld on the signing sheet). The GP did not cease the medications or document in the medical notes that he was aware the medications had been stopped. This resident was

prescribed liquid paracetamol during this time (documented by GP). The signing sheet shows this was administered at lunch, tea and bed time but not at breakfast time. On two occasions the medication was signed for twice although the assistant manager is certain this was a signing error and it was not given twice. Another resident is being administered Spiriva which has not been prescribed on the medication chart. (iv) One medication chart in use has the PRN medications signed by the GP but none of the regular medications. One resident was recently being administered a home remedy (antibiotic support) supplied by her family that was not charted by the GP (the remedy has since been stopped). These are areas requiring improvement. All caregivers have a current medication competency assessment. This is an improvement since the previous audit. As the registered nurses file was not available during the audit her competency assessment could not be sighted (link 1.2.7). D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly.

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 Moderate

Evidence:

Medication policies align with accepted guidelines. The medication policy has been updated to remove reference to the registered nurse not requiring a medication competency. This is an improvement since the previous audit. Medications are stored in a locked trolley the office. Controlled drugs are stored in a locked safe and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. This is an improvement since the previous audit. The service uses monthly blister packs that are packed by the pharmacy. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by the registered nurse or the manager (an enrolled nurse) and any pharmacy errors recorded and fed back to the supplying pharmacy.

Finding:

(i) There are expired suppositories and lotion in the utility (treatment) room. (ii) Of 10 medication charts sampled three have occasions when non packaged regular medications have not been signed as administered. (iii) One resident is reported by staff and a family member (interviewed) to have had all her medications stopped by the GP. These were not given for a month (and documented as withheld on the signing sheet). The GP did not cease the medications or document in the medical notes that he was aware the medications had been stopped. This resident was prescribed liquid paracetamol during this time (documented by GP). The signing sheet shows this was administered at lunch, tea and bed time but not at breakfast time. On two occasions the medication was signed for twice although the assistant manager is certain this was a signing error and it was not given twice. Another resident is being administered Spiriva which has not been prescribed on the medication chart. (iv) One medication chart in use has the PRN medications signed by the GP but none of the regular medications. (v) One resident was recently being administered a home remedy (antibiotic support) supplied by her family that was not charted by the GP (the remedy has since been stopped).

Corrective Action:

(i) Ensure all expired medications are disposed of or returned to the pharmacy. (ii) Ensure medications are administered as prescribed. (iii) Ensure medication charts are accurate and signed (iv) Ensure all home remedies are prescribed by the GP.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Parata Home cooks all food on site. There are three part time cooks. There is a four weekly rotating menu. The menu is currently being reviewed by a dietitian (on-going emails sighted with the most recent being dated 27 July 2014). This is an improvement since the previous audit. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. All fridges and freezers temperatures are recorded weekly on the recording sheet sighted and this is an improvement since the previous audit. All food in the freezer and fridge is labelled or dated and stored correctly and all decanted food is dated. This is also an improvement since the previous audit.

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook interviewed. Special diets are noted in a kitchen folder. Special diets being catered for include soft diets, and diabetic diets. Weights are recorded monthly as directed by the registered nurse (link 1.3.3.3 relating to weights not always being taken). Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted in a folder in the kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. One of the fridges in the kitchen has a significant area of damaged paint on the door meaning it can no longer be cleaned effectively. This is an area requiring improvement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

All fridges and freezers temperatures are recorded weekly on the recording sheet sighted and this is an improvement since the previous audit.

All food in the freezer and fridge is labelled or dated and stored correctly and all decanted food is dated. This is also an improvement since the previous audit. .

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook interviewed. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted in a folder in the kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.

Finding:

One of the fridges in the kitchen has a significant area of damaged paint on the door meaning it can no longer be cleaned effectively.

Corrective Action:

Ensure the door of the fridge is repaired or replaced.

Timeframe (days): 180 (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 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence: The previous audit identified that the chemical storage area /sluice room was not securely locked and there was one chemical dispensing container not labelled correctly. During this audit the sluice room where chemicals are stored is locked. All chemicals sighted during the audit were securely stored with bulk supplies kept in an external room. All chemicals sighted were correctly labelled. The previous shortfall has been addressed.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.2: 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: PA Moderate

Evidence:

Reactive and preventative maintenance occurs and this is an improvement since the previous audit. The maintenance person provided evidence of boiler maintenance. This is an improvement since the previous audit. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires on 14 June 2015. Electrical equipment has not been tested. This previously identified shortfall continues to require improvement. Medical equipment has not been calibrated and the hoist has not been serviced. These are areas requiring improvement. Hot water temperatures are monitored three monthly. Some readings are too hot and there is no evidence of corrective action taken. This previously identified shortfall continues to require addressing. The living areas are carpeted or vinyl and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas.

ARC D15.3: The following equipment is available, shower chairs, heel protectors, lifting aids.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Moderate

Evidence:

Reactive and preventative maintenance occurs and this is an improvement since the previous audit. The maintenance person provided evidence of boiler maintenance. This is an improvement since the previous audit. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires on 14 June 2015. Hot water temperatures are monitored three monthly.

Finding:

(i) Electrical testing and tagging has not been conducted. (ii) Medical equipment has not been calibrated. (iii) Hot water is tested three monthly but some readings are too high and no corrective action has been taken. (iv) There is no evidence of the hoist having been serviced.

Corrective Action:

(i) Ensure all electrical equipment is tested and tagged regularly. (ii) Ensure all medical equipment is calibrated according to the manufacturer's specifications. (iii) Ensure hot water temperatures are maintained in a safe range. (iv) Ensure the hoist is serviced annually.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service currently has two residents with bedrails in use as an enabler. No residents are using a restraint. Policy dictates that enablers should be voluntary and the least restrictive option possible. The manager and three of three caregivers interviewed are familiar with the definitions of an enabler and a restraint. The RN is the service's restraint coordinator. The manager/EN is the restraint coordinator in her absence.

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.)*

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The previous audit identified that for one resident using restraint, a restraint consent form had not been completed, no monitoring of the restraint was conducted when in use, policies and procedures had been archived and restraint minimisation education had not been conducted. Restraint policies and procedures have now been put into place but have not been reviewed (link to finding 1.2.3.3). Staff last received annual training around restraint minimisation and the management of challenging behaviours in 2013 (link to finding 1.2.7.5).

A process to gain consent for restraint and enablers is in place. Forms for monitoring restraint use are in place. No residents were using restraint during this audit. These previously identified shortfalls are now being addressed.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The previous audit identified there was no documented assessment for one resident using restraint. There were no restraints being used during this audit. The manager reports that when restraint is used, a restraint assessment is completed. A restraint assessment form was sighted which meets the requirements of the standard. This shortfall has now been addressed.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The previous audit identified the restraint register was not up to date. This shortfall has now been addressed.

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Infection surveillance is an integral part of the infection control programme and is described in Parata Home's infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. Resident infections are collated on a monthly reporting form which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored, graphed and evaluated monthly and annually. External support is provided from the DHB or the GP. Outcomes and actions are discussed at the staff/quality meetings. If there is an emergent issue, it is acted upon in a timely manner.

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.)*