# Chatswood Lifecare Limited

## Current Status: 13 October 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

Chatswood Lifecare is certified to provide rest home level care for up to 36 rest home and 28 hospital residents. On the day of the audit there were a total of 52 residents (26 rest home and 26 hospital). The service is currently being managed by a temporary manager with thirty years’ experience in aged care who has support from a clinical nurse manager and the owners (Chatswood lifecare Ltd) and staff. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed eight of the ten shortfalls from their previous partial provisional audit around human resources, aspects of medication management and aspects of the environment. Further improvements continue to be required around landscaping and medication documentation.

This audit identified improvements required around the quality programme, aspects of care planning and dating of decanted food in the kitchen. This audit also verified 14 serviced apartments as suitable to provide rest home level care. The environment has been assessed as suitable with an improvement required around establishing a draft roster.

## Audit Summary as at 13 October 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 13 October 2014

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

### Organisational Management as at 13 October 2014

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 13 October 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 13 October 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 low risk. |

### Restraint Minimisation and Safe Practice as at 13 October 2014

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

### Infection Prevention and Control as at 13 October 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## Introduction

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

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

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

## Audit Report

|  |  |
| --- | --- |
| **Legal entity name:** | Chatswood Lifecare Limited |
| **Certificate name:** | Chatswood Lifecare Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Chatswood Rest Home | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 13 October 2014 | **End date:** | 13 October 2014 |

**Proposed changes to current services (if any):**

This audit also included verified 14 serviced apartments as suitable to provide rest home level care. This will increase the overall bed numbers from 64 beds to 78 (50 rest home and 28 hospital).

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 52 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 10 | **Hours off site** | 8 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 10 | Total audit hours off site | 10 | Total audit hours | 20 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 11 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 44 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

I, XXXXXXX, 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, 3 November 2014

## Executive Summary of Audit

**General Overview**

Chatswood lifecare is certified to provide rest home level care for up to 36 rest home and 28 hospital residents. On the day of the audit there were a total of 52 residents (26 rest home and 26 hospital). The service is currently being managed by a temporary manager with thirty years’ experience in aged care who has support from a clinical nurse manager and the owners (Chatswood lifecare Ltd) and staff. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed eight of the ten shortfalls from their previous partial provisional audit around human resources, aspects of medications and aspects of the environment. Further improvements continue to be required around landscaping and medication documentation.

This audit identified improvements required around the quality programme, aspects of care planning and dating of decanted food in the kitchen. This audit also included verified 14 serviced apartments as suitable to provide rest home level care. The environment has been assessed as suitable with an improvement required around establishing a draft roster.

**Outcome 1.1: Consumer Rights**

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

**Outcome 1.2: Organisational Management**

Chatswood Retirement Village provides care for up to 64 residents across rest home (36) and hospital (28) level care. The service opened a new building in April 2014 to cater for up to 28 hospital residents. The service is privately owned and one of the owners owns another aged care facility. The temporary manager and clinical manager are responsible for the implementation of the quality and risk management programme. The quality and risk management programme includes service philosophy, goals and a quality planner. Key components of the quality management system link to monthly quality and monthly staff meetings. Improvements are required around completing audits as per the audit schedule 2014. Residents and family satisfaction surveys are completed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with residents and families identified that they are fully informed of changes in health status.

There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Improvements are required around staff appraisals and job descriptions. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is an improvement required around the development of a draft roster for the certified serviced apartments.

**Outcome 1.3: Continuum of Service Delivery**

The service has admission and entry policies and procedures. Needs assessment approval is required prior to entry for rest home and hospital level of care. Service information is made available in the facility brochures and booklets. Residents/relatives confirmed the admission process and the admission agreement were discussed with them. RN's are responsible for each stage of service provision. The sample of residents’ records reviewed provides evidence that the RN has completed an initial assessment and care plan on admission. There is evidence of resident/family participation in the development of the care plans. Long term care plans are reviewed at least six monthly. There is an improvement required around risk assessments, and interventions to support management of residents identified needs. Care plans demonstrate service integration and guide all staff in cares. The General Practitioner (GP) examines the resident within 48 hours of admission and three monthly thereafter. Resident files include notes by the GP and allied health professionals.

There are policies and procedures for medicine management. Registered nurses and caregivers responsible for the administration of medicines complete annual medication competencies and education. The medicines records reviewed include documentation of allergies and sensitivities. The GP reviews the medication records three monthly. Improvements are required around competency assessments for resident that are self-administrating medications. The activities programme is facilitated by a Diversional Therapist (DT). The activities programme provides varied options and activities that meet the consumer group. Each resident has an individualised activity plan. Improvements are required around completing activity assessment and care plan within the appropriate timeframe. Links with the community are maintained and van outings are arranged on a regular basis. All food is cooked on site. Residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. Food and fridge temperatures are recorded. Hot food temperatures are monitored. The cooks are qualified and all staff have undertaken food safety and hygiene training. There is an improvement required around dating of decanted foods.

**Outcome 1.4: Safe and Appropriate Environment**

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current certificate of public use. Resident rooms are spacious, some with ensuites, and adequate communal toilets and showers. There is wheelchair access to all areas. External areas are safe. There is an improvement required around outdoor seating and shading. There are spacious lounges and dining areas and smaller lounges available within the facility for quieter activities or visitors. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. All laundry is laundered on site. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has electric heating in the communal areas and in the bedrooms.

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

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit day.

**Outcome 3: Infection Prevention and Control**

The infection control (IC) programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. 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.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 12 | 0 | 6 | 1 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 6 | 1 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 51 |

## 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 1.2.3.1 | The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | Not all audits have been completed as per the 2014 audit schedule including (but not limited to), informed consent and continence (September), restraint (July) and staff meetings (March) | Ensure that all audits have been completed as per the audit schedule. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | (i)One staff member’s file reviewed does not evidence a job description.  (ii) One staff member file reviewed does not evidence a current staff appraisal. | (I)Ensure that all staff has a current signed job description. (ii) Ensure that all staff has annual staff appraisals completed. | 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 | This audit is assessing the service to provide rest home level care in 14 serviced apartments. The service has not developed a draft staff roster to cater for rest home residents in serviced apartments. | Ensure that there is a roster developed to accommodate serviced apartments. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (i)Two rest home files and two hospital files do not show evidence that weight loss and nutrition changes have interventions updated in the residents care plan to meet the residents needs and one hospital residents does not show evidence that interventions have been updated in the care plan to manage falls risk and meet the resident’s needs. (ii) One rest home file and one hospital file do not show evidence that risk assessments have been completed at the time of the care plan review. (iii) One hospital file does not show evidence that the activity assessment and care plan have been completed within the appropriate timeframe. | (i)Ensure that all interventions are updated in residents care plans to support the needs of the residents. (ii) Ensure that all risk assessments are completed at the time of the care plan reviews. (iii) Ensure that activity assessments and care plans are completed within the appropriate time frame. | 30 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Two rest home resident have not had competency assessments reviewed three monthly. | Ensure that all residents self-education have competency assessments completed three monthly. | 90 |
| 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 | Decanted foods have not been dated. | Ensure that all decanted foods are dated. | 90 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | The outdoor areas do not have seating or shaded areas. | Ensure that outdoor areas have seating and shaded areas. | 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:**

Residents stated they were welcomed on entry and were given time and explanation about services, and procedures. There is an open disclosure policy. The service has access to interpreter services and there is an interpreting policy. The service has a commitment to ensuring that the service is resident driven and focused. The service has a monthly newsletter for residents and families. Family are welcome at any time and are encouraged to be involved in resident care review. Interpreter services are accessible via the DHB.

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

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 and 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 of the service. Staff are aware of the complaints process and to whom they should direct complaints. 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. There have been four written complaints for 2014. Documentation sighted evidences resolution of the complaint to the complainant’s satisfaction. There is a complaints register which is current. Six residents (four rest home and two hospital) and five family (hospital) members advised that they are aware of the complaints procedure and how to access forms.

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:**

Chatswood lifecare provides care for up to 64 residents across rest home (36) and hospital (28) level care. The service opened a new building in April 2014 to cater for 28 hospital residents. On the day of the audit there were 26 rest home residents and 26 hospital residents. The 28 hospital beds are dual purpose beds. There are no residents on respite care on the day of the audit. The service is privately owned and one of the owners owns another aged care facility. The service is currently being managed by a temporary manager due to the resignation of the previous manager two weeks prior to the audit. The temporary manager has many years (30) in aged care management and works as a relief manager. The temporary manger is a registered nurse. The temporary manager is supported by a clinical manager who had management experience in health before coming to New Zealand. She worked in aged care in New Zealand as a caregiver since arriving in New Zealand in 2007 and as a registered nurse her since gaining her registration in March 2013. She has been in the current role since April 2013. The temporary manager reports that the DHB and HealthCERT have been informed of the credentials of a new manager that has been appointed to the role and is due to commence the position in in November 2014. The temporary manager and clinical manager are supported by an administration manager with 15 years aged care experience.

This audit also included verifying 14 serviced apartments as suitable to provide rest home level care. This will increase the total number of beds overall to 78 beds.

The service has a current strategic plan and quality plan for 2013- 2015. The quality programme is currently managed by the clinical manager with assistance from the temporary manager and registered nurses. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table (# link 1.2.3.1). Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee currently incorporates the temporary manage, clinical manager and the registered nurses. The committee meets monthly to assess, monitor and evaluate quality care at Chatswood. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The mission statement sets out to provide 'life style options for the older adults of the Opawa area and wider community." The service's philosophy includes “valuing and respecting not only residents and their extended family but also staff. That care is delivered is determined through a collaborative approach to meet the individual’s needs."

ARC, D17.3di (rest home): The temporary manager has completed at least eight hours of education relating to managing a hospital and rest home annually and reports to the owners who are regularly on site. The clinical manager has completed eight hours of education including but not limited to, wound assessment 2014, leadership course 2014 , infection control and prevention (three day course) April 2014, InterRAI training October 2014 and is currently completing post graduate studies. The organisation has a written business/quality plan for 2014. The quality management system identifies the vision, mission and objectives. The objectives include the plan to cater for hospital level residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service has a strategic plan and quality risk management plan that are implemented 2013-2015. Progress with the quality plan is monitored through the monthly quality/management meetings and monthly staff meetings. The quality/management meeting agenda and 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 easily available to staff.

Quality meeting minutes sighted for August 2014, staff meeting minutes for August 2014 and registered nurse meeting minutes for September 2014. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Chatswood commitment to on-going quality improvement. Discussions with two registered nurses (one rest home and one hospital), one enrolled nurse and four caregivers (rest home and hospital) confirm their involvement in the quality programme. Resident/relative meetings take place monthly (September 2014 minutes sighted). There is an internal audit schedule 2014 and internal audits are completed for but not limited to, care plans and infection control (January), cultural and spiritual and laundry/cleaning (February), complaints and informed consent (March), continence and medication (April), weight and nutrition (June), medication (July), and privacy and safety (September). Not all audits have been completed as per the 2014 audit schedule. This is an area requiring improvement. A care plan audit in July 2014 identified a number of care planning shortfalls and a corrective action plan has been developed. This has been reviewed in October 2014 with further corrective actions to be completed. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Annual review of the quality programme was conducted in October 2014.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.

The service contracts the services of a residential care nurse management consultant/auditor to assist in regular review of processes and policies. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

D5.4 The service has policies/ procedures to support service delivery; Policies and procedures align with the client care plans. Currently the temporary RN manager and clinical manager and the external consultant are responsible for policy review.

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

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

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

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

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by the temporary manager and clinical manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly quality meeting and monthly staff meeting. A resident/relative survey conducted in January 2014 evidences that residents and families are over all very satisfied with the service.

##### 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:** PA Low

**Evidence:**

There is an internal audit schedule 2014 and internal audits are completed for but not limited to care plans and infection control (January), cultural and spiritual and laundry/cleaning (February), complaints and informed consent (March), continence and medication (April), weight and nutrition (June), medication (July), and privacy and safety (September).

**Finding:**

Not all audits have been completed as per the 2014 audit schedule including (but not limited to), informed consent and continence (September), restraint (July) and staff meetings (March)

**Corrective Action:**

Ensure that all audits have been completed as per the audit schedule.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an adverse events policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at the monthly management meetings and monthly staff meetings including actions to minimise recurrence. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and five family (hospital) members interviewed stated they are informed of changes in health status and incidents/accidents. Five hospital incidents reports and four rest home incidents reports for August 2014 were reviewed. Incident reports reviewed include two skin tears, two behaviours and one fall (hospital) and two falls, one behaviour and one medication error (rest home). Monthly incident/accident analysis occurs with subsequent annual summary and analysis. Family are notified of incidents and accidents and this is documented on resident records (link 1.1.9).

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications and experience. A copy of practising certificates including the registered nurses, pharmacist, podiatrist and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one registered nurse, two caregivers, one DT and one clinical manager). Advised that reference checks are completed before employment is offered, these were evidenced in five staff files reviewed. Job description is evidenced in three of five files reviewed and staff appraisals are evidence in four of five files reviewed. This is an area requiring improvement.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This was a previous audit finding in regards to adding on hospital services that has now been addressed. Four caregivers (rest home and hospital) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in five of five staff files reviewed. Discussion with the clinical manager, two registered nurses (one rest home and one hospital), one enrolled nurse and four caregivers (rest home and hospital) confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements.

There is an in-service calendar for 2014. The annual training programme exceeds eight hours annually. Caregivers interviewed have either completed the national certificate in care of the elderly or have commenced the aged care education programme. The registered nurses and enrolled nurses attend external training including conferences, seminars and sessions provided by the local DHB. The clinical manager has attended education and training sessions from external providers in 2014 including post graduate studies and InterRAI training. Education provided in 2014 includes: quality control, palliative care, continence, manual handling, restraint minimisation, code of practice, challenging behaviour, fires safety, code of rights, abuse and neglect, Liverpool Care Pathway, chemical safety, open disclosure, cultural safety, infection control, and syringe driver use . The external nurse consultant has provided training in September 2014 on care planning and documentation for registered nurses.

##### 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:**

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications and experience. A copy of practising certificates including the registered nurses, pharmacist, podiatrist and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one registered nurse, two caregivers, one DT and one clinical manager. Advised that reference checks are completed before employment is offered, these were evidenced in five staff files reviewed. Job description is evidenced in three of five files reviewed and staff appraisals are evidence in four of five files reviewed.

**Finding:**

(i) One staff member’s file reviewed does not evidence a job description. (ii) One staff member file reviewed does not evidence a current staff appraisal.

**Corrective Action:**

(I)Ensure that all staff has a current signed job description. (ii) Ensure that all staff has annual staff appraisals completed.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home and hospital residents. The service is currently managed by a temporary manager with support from a clinical manager and a new manager has been appointed to commence the position in November 2014.

There is a registered nurse who works morning shifts in the rest home. There are three caregivers on the morning and afternoon shifts and one on night shift in the rest home.

There is one registered nurse on each shift in the hospital. There are four caregivers, one floater caregiver and one enrolled nurse that works in the morning in the hospital. There are four caregivers on the afternoon shift and two caregivers on the night shift in the hospital.

A dietitian is on contract and available as required. The service has employed the services of a physiotherapist four hours per week and also a physiotherapist assistant nine hours per week. The GP has increased his visits to twice weekly and is available on call. The DT has increased her hours to four days per week.

The clinical manager and temporary manager currently provide on call cover. Advised that extra staff can be called on for increased resident requirements. Interviews with four caregivers (rest home and hospital), two registered nurses (one rest home and one hospital), one enrolled nurse, six residents and five family (hospital) members identify that staffing is adequate to meet the needs of residents.

This audit is assessing the service to provide rest home level care in 14 serviced apartments (there are currently no rest home residents in the apartments). The service has applied to the MOH and has been given approval, however the service has not developed a draft staff roster to cater for the increased number of beds. This is an area requiring improvement.

##### 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 and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home and hospital residents.

**Finding:**

This audit is assessing the service to provide rest home level care in 14 serviced apartments. The service has not developed a draft staff roster to cater for rest home residents in serviced apartments.

**Corrective Action:**

Ensure that there is a roster developed to accommodate serviced apartments.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are a range of policies, procedures and flow charts to ensure the safe provision of services. These include an admission procedure and check list, initial care plan on admission, and role and accountability for implementing and evaluating the resident’s plan of care.

D16.2, 3, 4: The six files reviewed (three rest home and three hospital) identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks.

Two (one rest home and one hospital) of six resident care plans were written and reviewed by a RN and amended when current health changes (# link 1.3.6.1). The six long term resident care plans evidenced evaluations completed at least six monthly for rest home residents and three monthly for hospital residents.

Activity assessments and the activities sections care plans have been completed by an activities coordinator or the DT in five (three rest home and two hospital) files reviewed (# link 1.3.6.1).

There was documented review by physiotherapist, SLT, MHSOP, and podiatrist as needed in resident files.

Six residents (four rest home and two hospital) interviewed stated that they and their family were involved in planning their care plan and at evaluation.

Resident files documented family input through family contact sheets, family input, six monthly and three monthly evaluations and care plans.

D16.5e: All six 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 resident as stable and is to be seen 3 monthly or monthly ( with six long term files documenting that the GP had seen the resident more often).

A range of assessment tools where completed in resident files on admission and completed at least six monthly for rest home residents and three monthly for hospital residents including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Braden scale), c) continence assessment, d) nutritional assessment,, and e) pain assessment as evidence in two rest home files and two hospital files (# link 1.3.6.1).

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. The GP interviewed, who visits twice weekly and more often if needed, spoke very highly about the service and describes very effective communication processes.

Tracer Methodology Rest Home

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

Tracer Methodology Hospital

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Six resident files were reviewed (three from the rest home and three from the hospital). All identified that an initial nursing assessment and care plan was completed within 24 hours and all 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 as evidenced in one rest home file and one hospital file reviewed. This is an area requiring improvement. All three rest home care plans evidenced evaluations completed at least six monthly and all three hospital care plans evidenced care plans completed three monthly. Two rest home files and two hospital files evidenced risk assessments have been reviewed at this time. This is an area requiring improvement.

Activity assessments and the activities care plans have been completed by the diversional therapist or activities coordinator in three rest home files and two hospital files. This is an area requiring improvement. The care being provided is consistent with the needs of residents.

This is evidenced by discussions with residents, families, caregivers, two registered nurses, one enrolled nurse and the clinical manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of at least three monthly medical reviews.

Currently the temporary manager and clinical manager are responsible for the education programme and ensure staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers or registered nurses in the progress notes at least at least daily for rest home and hospital residents (evidenced in all six residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The four caregivers, two registered nurses, one enrolled nurse and the clinical nurse manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, 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 (four from the rest home and two from the hospital) and five hospital 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 seven rest home residents and seven hospital residents. Wounds include four skin tears, two ulcers, one chronic cellulitis/ulcer, one grade 1 heel pressure area (rest home residents) and four skin ears, one lesion, one blister, one reddened sacral area and one grade one heel pressure area (hospital residents ). All of the wounds have been reviewed within the stated timeframe. There is evidence of specialist input for two residents with wounds (# link 1.3.3).

The registered nurses 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.

Continence management in-services (March and May 2014) in-service has been provided. Wound management in-service has been planned for 2014.

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:** PA Moderate

**Evidence:**

Six resident files were reviewed (three from the rest home and three from the hospital). All identified that an initial nursing assessment and care plan was completed within 24 hours and all 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 as evidenced in one rest home file and one hospital file reviewed. All three rest home care plans evidenced evaluations completed at least six monthly and all three hospital care plans evidenced care plans completed three monthly however two rest home files and two hospital files evidenced risk assessments have been reviewed at this time. Activity assessments and the activities care plans have been completed by the diversional therapist or activities coordinator in three rest home files and two hospital files.

**Finding:**

(i)Two rest home files and two hospital files do not show evidence that weight loss and nutrition changes have interventions updated in the residents care plan to meet the residents needs and one hospital residents does not show evidence that interventions have been updated in the care plan to manage falls risk and meet the resident’s needs. (ii) One rest home file and one hospital file do not show evidence that risk assessments have been completed at the time of the care plan review. (iii) One hospital file does not show evidence that the activity assessment and care plan have been completed within the appropriate timeframe.

**Corrective Action:**

(i)Ensure that all interventions are updated in residents care plans to support the needs of the residents. (ii) Ensure that all risk assessments are completed at the time of the care plan reviews. (iii) Ensure that activity assessments and care plans are completed within the appropriate time frame.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a trained diversional therapist (DT) who works four days a week and an activity officer who works two days a week and activities are led by the activities team five days a week. The DT is part of a local DT group and attends meetings. Additional entertainment is provided on Saturdays, usually by a contracted entertainer. There is also an additional ‘happy hour' on Saturdays.

The activities coordinator and DT provide activities in the lounge areas and also provide one on one input in resident’s rooms when required. On the day of audit residents in both areas were observed being actively involved with a variety of activities. The programme is developed monthly and each day’s entertainment displayed on a large notice board. There is one programme that is planned by both activity staff. Residents have a choice of attendance.

Residents have an initial assessment completed and social profile over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc., and this is reviewed six monthly for rest home and three monthly for hospital as part of the care plan review/evaluation as evidence in five of six (three rest home and two hospital) # link 1.3.6.1. Progress notes are completed and records kept of daily activity attendance.

Community visits are assisted with the service van. The service also hires a wheel chair taxi van for hospital resident’s outings. Community involvement includes but not limited to churches services, shopping trips, library trips, working men’s club, friendship club and school children visits.

Participation in all activities is voluntary. The programme is comprehensive and caters for the individual needs. Activities include but not limited to exercise, housie, yoga, news and views, quizzes, bowls, one on one, walking group and crafts.

The DT runs the monthly resident meetings and feedback regarding activities is encouraged.

Six residents interviewed stated they were happy with the activities programme and were given choice regarding participation.

The activity programme can accommodate an increase in 14 rest home residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. Residents report they are satisfied with the activity programme offered to them by the facility.

##### 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:**

The six long term resident files documented at least a three monthly review by the medical practitioner. Care plans are reviewed and evaluated by the registered nurses six monthly for rest home residents and three monthly for hospital residents or when changes to care occur as sighted in one rest home file and one hospital file (# link 1.3.6.1). The six long term resident files documented that families had been in the evaluation process.

There are short term care plans to focus on acute and short-term issues. Changes to the long term care plan are made as required and at the six/three monthly review if required (# link 1.3.6.1).

STCP's are used, evaluated and updated as needed use included; infections, wounds, skin tears, challenging behaviours, skin excision and broken sacral area.

D16.4a Care plans are evaluated six monthly for rest home residents and three monthly for hospital residents or more frequently when clinically indicated (# link 1.3.6.1).

ARC D16.3c: All initial care plans for the six long term residents were evaluated by a registered nurse within three weeks of 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 Low

**Evidence:**

Chatswood has medication policies and procedures to support appropriate medication management. The service uses Douglas Medico medication management system. The packs are delivered monthly. All medication is checked on arrival to the facility by the RN and one other medication competent person. Medications have been prescribed and signed for by the resident's GP, all medication charts reviewed have photo identification of the resident attached. Any known allergies are documented on the residents' medication chart.

Staff sign for the administration of medications on medication sheets. This was a previous certification audit finding that has now been addressed. Medication competencies are undertaken by those administering medication.

Medications are stored in a medication trolley in a locked cupboard in the rest home and a treatment room in the hospital. There is a medication folder and trolley for each area. Controlled drugs are stored in a locked safe in the locked treatment room in the hospital. Controlled medications are checked weekly by the registered nurse. There are two controlled drug registers one for individual residents and one for stock controlled drugs. There is a medication fridge in the both medication storage areas and temperatures are recorded. Medications are administered by RNs and ENS in the hospital and some medication competent caregivers in the rest home. There is an annual competency undertaken and all staff administering medication, at the time of audit all competencies are current. Medications for residents in serviced apartments are managed by the rest home.

The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible, signed and dated and able to meet acceptable good practice standards. There are policies in place to guide practice. There is evidence of three monthly GP review. A medication audit has been completed in August 2014 and medication and syringe driver training has been competed in July 2014.

D16.5.e.i.2; Eleven of twelve medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed (one hospital resident has been at the service less than three months).

There is a self-administered medicines policy and procedure. There are two rest home residents self-medicating on the day of audit. Competency assessments have not been carried out three monthly. This was previous audit finding that still requires further improvement.

Eleven of 12 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Medication profiles are legible and up to date.

All eye drops currently in use have been dated when opened.

One enrolled nurse from the hospital and one registered nurse form the rest home were observed safely and correctly administrating medications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a self-administered medicines policy and procedure. There are two rest home residents self-medicating on the day of audit.

**Finding:**

Two rest home resident have not had competency assessments reviewed three monthly.

**Corrective Action:**

Ensure that all residents self-education have competency assessments completed three monthly.

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

##### Criterion 1.3.12.6 (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:**

The service has a large new commercial kitchen that includes a bain marie for serving to the new dining room, a walk in freezer, walk in chiller and large walk in pantry, a night fridge and pantry, one further fridge, a steriliser, a commercial oven, gas hobs, a grill, an extractor fan, a commercial mixer and a microwave. Equipment for mouling food is in use and there is a hot box to transport food to residents in other areas. All meals are cooked on site, including home baking. The two cooks have completed food safety certificates. The main cook is currently completing level three cooking qualification through service IQ. There is a comprehensive food services programme which includes the food safety programme.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Food temperatures are also recorded daily. There is a daily kitchen journal kept with all recorded temperatures and meals documented for the day including daily food waste. Food is covered and dated however decanted food has not been dated. This is an area requiring improvement.

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly for rest home residents and three monthly for hospital residents as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook and staff. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets, one gluten free and diabetics. There is a rotating four weekly seasonal menu in place. A dietitian reviewed the menu in January 2014

Meal times observed evidenced that staff are available and assist the residents with meals as needed. The meal time was also noted to be a relaxed times with residents given as much time as needed to enjoy their meals. Equipment is available on an as needed basis. Residents requiring extra assistance to eat and drink are assisted, this was observed during lunch. There is special equipment for eating e.g. lipped plates and thick handled spoons

Six long term resident files all documented monthly weighs (# link 1.3.6.1). The cook interviewed reports increasing puddings, creams, ice creams milk shakes and food supplements for residents with weight loss issues.

Six residents (four rest home and two hospital) report satisfaction with food services.

The kitchen already supplies meals to residents in the serviced apartments and can accommodate an increase in 14 rest home resident in the serviced apartments. The serviced apartment area has a dining room.

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

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

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

**Attainment and Risk:** 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:**

The service has a large new commercial kitchen that includes a bain marie for serving to the new dining room, a walk in freezer, walk in chiller and large walk in pantry, a night fridge and pantry, one further fridge, a steriliser, a commercial oven, gas hobs, a grill, an extractor fan, a commercial mixer and a microwave. Equipment for mouiled food has been purchased and there is a hot box to transport food to residents in other areas. All meals are cooked on site, including home baking. The two cooks have completed food safety certificates. There is a comprehensive food services programme which includes the food safety programme.

Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Food temperatures are also recorded daily. There is a daily kitchen journal kept with all recorded temperatures and meals documented for the day including daily food waste. Food is covered and dated.

**Finding:**

Decanted foods have not been dated.

**Corrective Action:**

Ensure that all decanted foods are dated.

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

There are documented policies; procedures and an emergency plan to respond to significant waste or hazardous substance management. Chemical safety training was provided April 2014 and 19 staff attended. Chemicals are stored in a dedicated locked cleaners cupboard. This was a previous audit finding that has now been addressed.

There is personal protective equipment. The service has a sluice room in the, which has a steriliser, and two sinks, one of which is a sluice sink and has a hose attachment. There is an accident/incident system for investigating, recording and reporting incidents. There was no incident or accident reports involving infectious material, body substances or hazardous substances sighted. There is an emergency manual available to staff which includes hazardous substances.

##### 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.)*

##### Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used 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.)*

#### 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 Low

**Evidence:**

The service currently has a Certificate of Public Use which expires 1 June 2015. There is a risk management plan that includes management of security, health and safety and emergency management. There is sufficient space so that residents are able to move around the facility freely. There is non-slip lino in showers and toilet areas throughout the new wings. The main hallways, bedrooms and living areas are carpeted. The dining area has vinyl laid. This was a previous audit finding that has now been addressed. Handrails are installed in hallways. This was a previous audit finding that has now been addressed.

Residents are able to bring their own possessions including furniture to their bedroom. There is a transportation of resident’s policy.

The new unit consists of one 18 bed wing and one ten bed wing, which are joined by a large open plan lounge and dining area. All rooms are large and suitable for either rest home or hospital level care. They all have one and a half width opening doors. All rooms can accommodate equipment e.g. hoists, extra staff if required and all can be accessed by a hospital bed and ambulance stretcher. Nine rooms have ranch sliders that have external access. All rooms have en-suites that are large enough to cater for hospital level residents including equipment such as hoists and up to two carers.

There are a number of outdoor areas including an internal courtyard that are accessible by residents using mobility aids. These are yet to have seating and shade provided. This was a previous audit finding that still requires improvement.

The service has purchased new equipment for providing hospital level care.

All existing medical equipment has been calibrated within the last 12 months. Hot water temperatures are checked monthly and compliant. There is water or electricity in the facility. These were previous audit finding that have now been addressed.

This audit identifies that the serviced apartments (14) are appropriate for rest home level care.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are a number of outdoor areas including an internal courtyard that are accessible by residents using mobility aids.

**Finding:**

The outdoor areas do not have seating or shaded areas.

**Corrective Action:**

Ensure that outdoor areas have seating and shaded areas.

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

#### Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

**Attainment and Risk:** FA

**Evidence:**

There is a large new laundry in the new wing that has sufficient space to cater for all residents at the facility including the 28 new residents. The laundry has a dirty to clean flow and an external door. There is a large drying room and a large folding area. Two commercial washing machines have been installed and are operational. This was a previous audit finding that has now been addressed. Cleaning and laundry services are well monitored throughout the internal auditing system - last audit in July 2014. The laundry has a clean/dirty flow and chemicals are stored securely. Staff receive training at orientation and through the in-service programme. There are appropriate policies and product charts. There are rooms available for storage of chemicals.

The laundry and cleaning rooms are designated areas and clearly labelled. All chemicals are labelled with manufacturer’s labels. MSDS are available in folders. All chemicals were noted to be secure during the audit. There are dedicated cleaning and laundry staff. The laundry is large enough for the increase in residents. There is a sluice room in the new wing.

##### Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

**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 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

**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 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

**Attainment and Risk:** FA

**Evidence:**

The new building has a NZ Fire Service approved the evacuation scheme (20 May 2014). This was a previous audit finding that has now been addressed.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation sighted for the existing rest home. Fire training has been provided in May 2014 and 27 staff attended. Fire warden training has been provided in September 2014 and ten staff attended. A contracted service provides checking of all facility equipment including fire equipment.

Security is covered in the orientation package as part of the health and safety session.

Emergency equipment is available at the facility. Civil emergency boxes were sighted. First aid training has been provided for staff and there is at least one person on each duty with a current first aid certificate.

There is emergency lighting at the facility. There is a large cupboard with civil defence material available. There is sufficient stored water to support residents for at least three days in the event of an emergency.

Corridors are wide enough to allow residents to pass and to get to egress points quickly in the event of a disaster.

All rooms and communal areas have call bells that link to the rest home and alert on panels throughout the facility. There are call bells in the apartments linked to the call bell system in the rest home. The call bell system is now operational. This was a previous audit finding that has now been addressed.

##### Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

**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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation 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.)*

##### Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

**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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

**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:**

Documented systems are in place to ensure the use of restraint is actively minimized. The clinical manager is the restraint coordinator. The facility was not utilising restraint or enabler use on audit day. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

Staff education on challenging behaviour management was conducted in April 2014 (14 staff attended) and July 2014 (12 staff attended). Restraint education conducted in April 2014 (14 staff attended). Restraint minimisation and safe practice audits have not been completed as per the audit schedule for 2014 (# link 1.2.3.1)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Chatswood rest home's infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since 2012. Two registered nurses (one rest home and one hospital), one enrolled nurse (hospital) and four caregivers have an understanding of infection control prevention and management.

##### 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.)*