

# M V and C D Hodson

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** M V and C D Hodson

**Premises audited:** Westella Homestead

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 24 November 2014    End date: 24 November 2014

**Proposed changes to current services (if any):** Westella Homestead is providing dementia level care. The service provider is transitioning from rest home and dementia level care to dementia level care only.

**Total beds occupied across all premises included in the audit on the first day of the audit: 23**

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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

## General overview of the audit

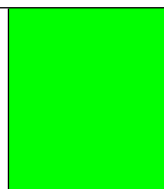
Westella Homestead provides dementia and rest home level care for up to 26 residents and occupancy was 23 on the day of this audit. The facility is operated by MV and CD Hodson.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the District Health Board contract. This audit included a review of the nine aspects of service provision where shortfalls were identified during the last audit in June 2013, five of which have been addressed. The four areas still requiring improvement relate to quality and risk management documentation, staff education, documentation relating to building maintenance and dementia specific entry information. Two additional shortfalls were identified relating to the management of un-witnessed falls and resident documentation.

The service provider won the best use of technology in health care award during the local District Health Board 2014 health awards. The provider uses technologies to assist with the management of dementia related behaviours in the least restrictive manner.

## Consumer rights

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.



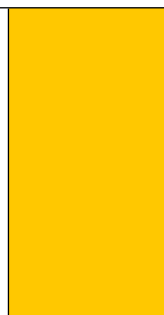
Standards applicable to this service fully attained.

Residents and family members interviewed reported that they are happy with the services provided and that their rights are respected. Family and residents reported there is good communication between them, staff and management. There was documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms. The facility manager is responsible for complaints and a complaints register is maintained. The residents and their family members can use the complaints issues forms as well as raising issues directly with staff or via the residents' meetings.

The previous issue relating to consent documentation has been addressed.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

MV and CD Hodson is the governing body and are responsible for the service provided at Westella Homestead. Dalcam Healthcare Limited is contracted to provide management services at Westella Homestead. Planning documents reviewed included a business plan, a mission statement, vision and values statements, and philosophy. An organisational chart was also reviewed. An experienced facility manager, who is a registered nurse, is responsible for management of the facility and for oversight of clinical care. They are supported by the general manager from Dalcam Healthcare Ltd and by a registered nurse.

The quality and risk management systems have been maintained since the last audit. The shortfall identified during the last audit concerning analysis of quality improvement data has been addressed as there is evidence that quality improvement data has been collected, collated and analysed for trends. There was an issue concerning the documentation and monitoring of corrective action plans to address any shortfalls identified. This has been partially addressed as corrective action plans are being documented but they do not consistently evidence responsibilities and timeframes for implementation and completion of corrective actions.

A hazard register is available that has risks documented. Adverse events are documented on an electronic database. Improvements are required with the management of un-witnessed falls as neurological observations are not being completed following these events.

The shortfalls identified during the last audit relating to evidence that staff had completed an orientation and an issue with staff in-service education have been addressed. There is not at least one staff member on duty at all times with a current first aid certificate and this requires improvement.

There is a documented rationale for determining staffing levels and skill mix and the minimum number of staff is provided during the night shift and consists of two care givers. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents receive services from suitably qualified and experienced staff. Evaluations are documented, resident-focused and indicate the degree of response to interventions and meeting desired outcomes. Where the progress of a resident is different from what is expected, the service responded by initiating changes to the long term care plan. Family have the opportunity to contribute to long term care plans. Service delivery does not consistently include 24 hour management plans for residents who receive dementia level of care (refer 1.3.3.3) and where residents experience un-observed falls neurological observations are to be completed (refer 1.2.4.3).

Reviewed files evidence Initial care plans, short term care plans for acute conditions and long term long term care plans for service delivery. Resident, nursing and medical reviews are conducted within the required timeframes. Activities are planned and appropriate to the level of service delivery.

The medicines management system provides safe and appropriate prescribing, review, storage, disposal and reconciliation, all staff members who administer medicines complete annual competencies. Medicine management training is conducted annually. The medicines policy includes a section on the self-administration of medicines. There were no residents self-administering medicines. Medicines fridge temperatures were maintained and recorded.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines appropriate to the needs of the residents. Menus are reviewed annually. The cook ensures dietary needs of the residents are met. Kitchen staff completed food safety training.

The shortfall identified in the last audit relating to specific dementia care services information to be available to prospective residents had been addressed in the corrective actions post audit, however this remains a finding as the information provided still requires improvement.

## Safe and appropriate environment

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.
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The issue identified during the last audit relating to evidence of calibration of scales and other biomedical equipment has been addressed. Management of maintenance documentation and electrical testing and tagging requires improvement. A current Building Warrant of Fitness is displayed.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Documentation of restraint minimisation and safe practice policies and procedures demonstrate residents are experiencing services with no physical restraints. The service does not use any enablers. The shortfall identified in the last audit relating to rest home residents being restrained by having them live in a secure environment has been addressed.

## Infection prevention and control

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.

Surveillance is appropriate to the size and complexity of the service. Review of documentation provides evidence that the service has a surveillance reporting process that includes feedback at staff meetings and reports to management. The clinical manager collates infection control information. Data is recorded and reported as clinical indicators and expressed in graphs and charts.

Infection control education is provided annually as part of the in-service training programme. Staff members complete annual infection control competency training, including hand-washing techniques.



## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	13	0	3	3	0	0
<b>Criteria</b>	0	41	0	2	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The clinical manager, and RNs report informed consent is discussed and is recorded at the time the resident is admitted to the facility.</p> <p>Residents/family are provided with various consent forms on admission for completion as appropriate and are reviewed on resident's files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident's files.</p> <p>Staff interviewed demonstrate a good understanding of informed consent processes.</p> <p>Residents and family interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.</p> <p>Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme</p>

		<p>includes education on the Code of Rights. The previous requirement for improvement relating to consents have been fully implemented. All residents who do not have advanced directives, signed by the resident, are for resuscitation.</p> <p>The district health board contract requirements are met.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes complaints received verbally as well as in writing.</p> <p>The general manager and facility manager advise there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. The general manager advised the Ministry of Health undertook an unannounced audit following the last audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrate an understanding and awareness of these processes.</p> <p>A visual inspection of the facility provided evidence that the complaint process is readily accessible and/or displayed. Review of quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff interviewed confirmed this information is reported to them via their staff meetings.</p> <p>The relevant District Health Board contract requirements are met.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files (electronic and hard copy) reviewed for three dementia and two rest home level residents provided evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded in the residents electronic records.</p> <p>Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for</p>

		<p>their care.</p> <p>The facility manager advises access to interpreter services is available if required via the District Health Board and the local community if required. They also advise there are currently no residents who require interpreter services.</p> <p>The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Five admission agreements were reviewed and this is clearly communicated in each agreement.</p> <p>The relevant District Health Board contract requirements are met.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>MV and CD Hodson Partnership is the governing body and are responsible for the service provided at Westella Homestead. MV and CD Hodson Partnership have contracted the management of Westella Homestead to Dalcam Healthcare Limited (Dalcam). The general manager for Dalcam was interviewed and advised they report to one of the directors of Dalcam, who is also one of the partners of MV and CD Hodson Partnership, monthly via formal reports.</p> <p>The organisation has a documented strategic plan for the period 2014 to 2019 as well as a business plan for the 2014 – 2015 period, a quality plan, and a risk management plan. Also reviewed was a mission statement, vision, values and mission statement and an organisational chart. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>The facility manager, who is an experienced registered nurse, is responsible for the day-to-day management of the facility. The facility manager is also responsible for oversight of clinical care provided and they are supported by a registered nurse and an enrolled nurse. There is a registered nurse on site from Monday to Saturday inclusive and an enrolled nurse is on site on Sundays.</p> <p>The personal files for the facility manager and the registered and enrolled nurses are reviewed and all three have current practising certificates, job descriptions and evidence of ongoing education.</p> <p>Westella Homestead is currently certified to provide 26 rest home level beds. The general manager advised they are currently transitioning from rest home and dementia level care to total dementia level care. There were five residents assessed as requiring rest home level care during this audit and all have consented to being in</p>

		<p>a secure environment. These residents report they are able to leave the facility if they wish. There were 18 residents assessed as requiring dementia level care and two of these residents are aged less than 65 years.</p> <p>The service provider has contracts with the District Health Board (DHB) to provide aged related residential care (rest home and dementia), respite and day care services, and long term support - chronic health conditions.</p> <p>The relevant District Health Board contract requirements are met.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>One of the two shortfalls identified during the last audit has been addressed and the other shortfall has been partially addressed. There is evidence that quality improvement data is being collected, collated, evaluated, analysed for trends and reported to staff and the governing body. The shortfall concerning the documentation and monitoring of corrective action plans to address any shortfalls identified has been partially addressed. Corrective action plans are being documented but they do not consistently indicate responsibilities and timeframes for implementation and do not always provide evidence of completion of the corrective actions (see criterion 1.2.3.8).</p> <p>A business plan and quality plan with goals and objectives were reviewed, as were documented values, mission statement and philosophy. A hazard register was reviewed that identified health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual was available that includes relevant policies and procedures.</p> <p>The facility manager advised that staff, quality and resident meetings are held monthly; minutes reviewed and staff and residents interviewed confirm this. Family and resident surveys were completed in May 2014 and the collated results for these surveys indicate residents and family are 'very satisfied' with the service provided.</p> <p>Quality and staff meeting minutes are available for review by staff. These minutes provide evidence of reporting on clinical indicators including numbers of infections and adverse events. This finding is confirmed during staff interviews as staff report they are advised of the numbers of infections and adverse events via their staff meetings.</p> <p>Clinical indicators, adverse events and quality improvement data is recorded and</p>

		<p>were reviewed as part of this audit.</p> <p>There are policies and procedures that identify quality outcomes for key components of service delivery, including quality and risk management. Health and safety information is available that includes relevant policies and procedures and there is a hazard reporting system available and a hazard register. Chemical safety data sheets are available that identify the potential risks for each area of service. All biomedical equipment has appropriate performance verified stickers in place.</p> <p>Not all of the relevant District Health Board contract requirements are met</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>PA Moderate</p>	<p>Staff are documenting adverse, unplanned or untoward events on an electronic register. The registered nurse (RN) reported they are advised of all adverse events where there is an injury to a resident. They advise an RN undertakes an assessment of these residents. The assessment does not include neurological observations for all unwitnessed falls and for injuries resulting in head wounds (see criterion 1.2.4.3).</p> <p>Adverse events are collated and graphs of incidents and accidents are generated monthly by the electronic database. The facility manager writes a narrative report that includes an analysis of these events which is presented to the monthly quality and staff meetings. Minutes of meetings and graphs are reviewed and provide evidence of reporting of numbers of incidents/accidents.</p> <p>The general manager advises they notify the District Health Board of all instances of residents who leave the site without support/supervision via the gate nearest the road. They also advised that there has been one instance where a resident was returned to the facility by police and that they notified this event to the Ministry of Health.</p> <p>Resident records reviewed provide evidence of communication with family and GP following adverse events and if there is any change in the resident's condition. Family members and the general practitioner interviewed confirm they are notified in a timely manner. There is an open disclosure policy.</p> <p>Staff confirm during interview that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures, which is confirmed via review of documentation. Staff also confirmed they are recording accidents and incidents on the electronic database.</p> <p>Not all of the relevant District Health Board contract requirements are met.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Criterion 1.2.7.4 was partially attained during the last audit and is now fully attained. There is evidence on the staff files reviewed that staff have completed an orientation.</p> <p>Criterion 1.2.7.5 was also partially attained during the last audit and remains, as a new issue relating to staff education has been identified. Copies of annual practising certificates are reviewed for all staff that require them to practice and are current.</p> <p>There are written policies and procedures in relation to human resource management which comply with current good employment practice. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files.</p> <p>Care staff interviewed (four caregivers and one RN) report they have completed an orientation, including competency assessments (as appropriate).</p> <p>The facility manager is responsible for the in-service education programme and in-service education is provided at least monthly. Staff are supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care. Staff are required to complete the dementia specific unit standards and with the exception of the two new caregivers, all staff have either completed or are working towards completing these standards. Staff files reviewed indicate at least eight hours of training annually.</p> <p>Not all the relevant District Health Board contract requirements are met.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale (staff levels and rationale) in place for determining service provider levels and skill mixes in order to provide safe service delivery at Westella Homestead. Registered nurse (RN) cover is provided six days a week (Monday to Saturday inclusive) between 8.30am and 4.30pm. An enrolled nurse works between 7am and 3.30pm on Saturdays and Sundays. Additional RN support is available 24 hours a day from a nearby sister facility. The minimum amount of staff on duty is between 11.30pm and 7.30am and consists of two caregivers.</p> <p>Care staff interviewed report there is adequate staff available and that they are able to get through their work. Residents and family interviewed report staff provide them with adequate care.</p>

		The relevant District Health Board requirements are met.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	PA Low	<p>The service has changed the information in the information pack and the admission agreement that is available to new residents and the public, sighted the information pack and the admission agreement. One aspect of the previous requirement for improvement; relating to information specific to dementia care to be included in the information made available to prospective and new residents remains open as the information is not currently fully meeting the requirements of the contractual agreement with the District Health Board.</p> <p>The second part of the requirement for improvement relating to the service not having a separate secure dementia unit has been addressed as the entire environment (7.5 acres) is secure.</p> <p>The contractual requirements of the District Health Board are not fully met.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medicines are dispensed and delivered by the pharmacy. All medicine prescribed were signed by the general practitioner (GP). Each resident file reviewed had an individual medicines profile and medicine prescription form with an individually dispensed rolls of medicines and medicine signing sheets. The GP, with input of the registered nurse completed medicine reconciliation on admission for each resident.</p> <p>A controlled drug register is maintained in the nurses' station and evidenced weekly checks by the registered nurses. Controlled drugs are stored securely. The service does not have standing orders. Medicines requiring refrigeration are stored in a dedicated fridge and kept in the secure nurses' station. The medicines fridge temperatures are recorded on a daily basis and are within the recommended temperature range for medicines.</p> <p>Medicine reviews by the GPs were recorded in the medicine charts and reviewed three monthly, confirmed in medicine files reviewed. There is evidence staff are signing off as the dose is administered, observed during the medication round in the hospital.</p> <p>Staff responsible for medicine management, receive on-going education, and have current medicine competencies signed off. Medicines were observed to be managed in a safe and appropriate manner. The medicines policy includes self-administration</p>



		<p>of medicines. There were no residents self-administering their own medicine.</p> <p>The contractual requirements of the District Health Board are met.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food and nutritional needs of residents are provided in line with recognised nutritional guidelines that are appropriate to the needs of the residents. The cook has been in the role for six months and has completed food safety training. Menus are planned on a four weekly cycle. The cook is responsible for ordering food and ensuring fridge/freezer monitoring occurs, sighted records.</p> <p>Special dietary needs are identified through assessment on admission and communicated to the cook, confirmed during the interview with the cook and sighted copies of dietary assessments. Special equipment is available for those that require lipped plates, spout cups and beakers.</p> <p>Food procurement, production, preparation, storage, transportation, delivery and disposal comply with legislation. The cook is knowledgeable regarding prevention and control of infection. Personal protective equipment (PPE) such as aprons and hats and gloves are available and worn by kitchen staff.</p> <p>The contractual requirements of the District Health Board are met.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation and observations made of service provision and/or interventions demonstrated that consultation and liaison is occurring with other services. All of the residents' files reviewed provided evidence that care plans record appropriate interventions, however residents who experience un-observed falls did not have neurological observations completed (refer 1.2.4.3).</p> <p>Goals are developed and the required interventions implemented to achieve them. Services are delivered in a manner that supports the resident to maintain strengths and live safely in a secure environment.</p> <p>Interventions are based on the assessed needs, desired outcomes or goals of the residents. The general practitioner's documentation and records are current. Visual inspection of the service evidenced adequate continence and dressing supplies in accordance with requirements of the service agreement. Residents and family interviews confirmed care and treatments meet their needs. The family communication sheets record contact and communication with family.</p>

		The contractual requirements of the District Health Board are met.
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>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.</p>	FA	<p>Written activities are planned and displayed for residents and family to see. The activities reflect the skills, strengths and the interests of the residents. Interviews with residents confirm they participate and enjoy activities. The diversional therapist (DT) works 40 hours per week, providing activities meeting the needs and goals of residents, including two residents who are under the age of 65.</p> <p>The DT attends monthly meetings with other activities coordinators and diversional therapists. Each resident file has an activities plan, attendance record and a diversional therapy evaluation sheet completed for the resident. Activities are reviewed six monthly, sighted reviewed activity plans for five resident files reviewed during the on-site audit.</p> <p>Activity goals include physical, intellectual, cultural and spiritual needs of residents. Outings take place and residents have signed consents for going on outings, on record. Residents were observed playing cards and participating in physical exercises during the on-site audit.</p> <p>The contractual requirements of the District Health Board are met.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents and family interviews confirmed their participation in care plan evaluations and review. There was recorded evidence of input from professional, specialist and multi-disciplinary sources, for example nurse practitioners, physiotherapist, podiatrist and the dietitian. Residents' files evidence referral letters to specialists and other health professionals. Short term care plans were in place for short term changes in condition. Updated care plans reflect changes in the condition of residents.</p> <p>Resident files reviewed evidence timely review of care plans.</p> <p>The contractual requirements of the District Health Board are met.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate,</p>	PA Low	<p>A maintenance person is contracted for 20 hours a week. External contractors are</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>used for plumbing, electrical and other specialist areas. Planned and reactive maintenance systems are in place. Maintenance requests are recorded on an electronic database which is reviewed each day by the maintenance person. The electronic maintenance register is not updated to reflect the status of the maintenance request (see criterion 1.4.2.1).</p> <p>The issue identified during the last audit relating to evidence of calibration of scales and other biomedical equipment has been addressed and current calibration/performance verified stickers are in place on medical equipment. However, expired electrical safety tags are viewed on electrical items (see criterion 1.4.2.1). Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 1 November 2015.</p> <p>There have been no alterations to the building since the last audit. Buildings, facilities, furnishings, equipment and medical devices are well maintained and are suitable for the care and support of aged care residents.</p> <p>A visual inspection of the facility provides evidence of safe storage of medical equipment. Corridors are wide and residents were observed safely passing each other; safety rails are secure and are appropriately located.</p> <p>The entire site is secured by electronic gates with security cameras and high fences. Residents are able to wander freely throughout the facility and grounds. GPS tracking is used for residents who have been identified with dementia related wandering. The external areas are safely maintained and are appropriate to the resident groups and setting. Residents are protected from risks associated with being outside (eg, provision of adequate and appropriate seating; provision of shade; and ensuring a safe area is available for recreation or evacuation purposes).</p> <p>Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>Not all the relevant District Health Board requirements are met.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	<p>FA</p>	<p>Bedding and towels are washed off-site by an independent contractor. Residents'</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>personal clothing is washed on site and there is adequate dirty / clean flow in the laundry.</p> <p>Visual Inspection provided evidence that cleaning and laundry processes are implemented. Visual inspection also provided evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.</p> <p>Residents interviewed state the cleaning and laundry service is adequate. This finding is confirmed during review of completed family and resident satisfaction surveys.</p> <p>The relevant District Health Board contract requirements are met.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The service infection control coordinator (ICC) is responsible for collecting surveillance data. The ICC confirmed understanding the responsibilities relating to the role, sighted the job description. Surveillance data is collected monthly, sighted monthly surveillance reports for September, October and November 2014. Interview with the ICC confirms infection control education and training occurs annually, including hand-washing techniques.</p> <p>The infection control programme is reviewed annually. Infection control surveillance includes graphs and statistics to support management reports. Interviews and meeting minutes confirm feedback to the quality committee and at staff meetings. The Infection control committee forms part of the quality committee.</p> <p>The service participates in internal benchmarking within Dalcam Healthcare Limited as well as external benchmarking with similar services.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrates that the use of restraint is actively minimised. There is no evidence of any residents using physical restraints or enablers. Interviews with residents and their family members confirm physical restraint and enablers are not being used in the facility.</p> <p>The previous requirement for improvement relating to rest home residents not to be</p>

		<p>restrained is fully implemented. The five rest home residents that chose to stay with the facility after rest home level of care changed to dementia level of care, consented to being enclosed in the 7.5 acres of environmental restraint (refer 1.3.3), as they did not want to leave the facility. Review of these residents' files evidenced written consent records.</p> <p>The contractual requirements of the District Health Board are met.</p>
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## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>An internal audit schedule is reviewed that list audits to be completed on a month-by-month basis. Internal audits have been completed as per the audit schedule.</p> <p>A shortfall was identified with development and monitoring of the corrective action plans during the last audit and this has been partially addressed. Completed internal audits include corrective action plans to address shortfalls identified.</p>	<p>(i)The person/s responsible for implementing corrective actions and the timeframe/s for implementation of these are not consistently documented; and (ii) there is minimal documentation available to indicate the corrective action has been completed and monitored for effectiveness.</p>	<p>Provide documented evidence that</p> <p>(i)The person/s responsible for implementing corrective actions and the timeframe/s for implementation of these is being consistently documented; and (ii) Documentation is available to indicate the corrective action have been completed and are monitored for effectiveness.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward</p>	<p>PA</p> <p>Moderate</p>	<p>The facility manager advised they review all adverse events as well as resident’s event notes each morning when they start work. The registered</p>	<p>Provide evidence that neurological observations are being completed for all unwitnessed falls, if the resident</p>	<p>Provide evidence that neurological observations are being completed for all unwitnessed falls, if the resident has an obvious head</p>

<p>events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>		<p>nurse reported they are required to assess and monitor all adverse events that result in an injury to the resident.</p> <p>The two residents whose files were selected for tracer reviews both had unwitnessed falls resulting in injuries. One of these residents had lacerations to their face, however neurological observations were not undertaken (see link 1.3.3.)</p>	<p>has an obvious head injury, or if they have a fall that could result in a possible head injury.</p>	<p>injury, or if they have a fall that could result in a possible head injury.</p> <p>30 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Inservice education calendars for 2014 and 2015 are reviewed and indicate education is provided at least monthly via an on-line learning programme. On-line learning is supplemented by other education sessions provided by specialist educators. Education attendance records are maintained and with the exception reported below, staff have received education in the core topics.</p> <p>Seven staff have first aid certificates that expired in September 2013. A qualified first aid trainer is employed at a sister facility and is scheduled to provide first aid training for some of the staff on 3 December and 4 December 2014 so that there is at least one person on each shift with a current first aid certificate. The general manager and facility manager advised they plan to ensure that all staff have current first aid certificates.</p>	<p>At least one staff member with a current first aid certificate is not available on each shift.</p>	<p>Provide evidence that there is at least one staff member on each shift who has a current first aid certificate.</p> <p>30 days</p>

<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	<p>The service has revised the admission agreement to include dementia level of care service; however the information available to the public and prospective new residents is not currently fully meeting the requirements stated in the contract with the District Health Board.</p>	<p>The documentation provided to new residents and their family does not include all of the requirements identified in the funding contract with the District Health Board. (E4.1b)</p>	<p>Provide evidence that admission information provided to new residents and their family includes all relevant information as identified in the funding contract.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Moderate	<p>Three residents receiving dementia level of care had their personal files reviewed during the on-site audit. Two of the three residents did not have 24 hour challenging behaviour management plans to guide staff in the management of challenging behaviour, on record.</p>	<p>Not all residents receiving dementia level of care have 24 hour challenging behaviour management plans on record.</p>	<p>All residents who receive dementia level of care to have 24 hour challenging behaviour management plans in place to help guide service providers in service delivery when residents present with challenging behaviour.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>An electronic database is used to record maintenance requests. The general manager is interviewed and advised the maintenance person checks this electronic database each day. The electronic maintenance register was reviewed and maintenance requests are not marked as being completed. Some of the maintenance requests on this register were reviewed and maintenance has been completed.</p> <p>Electrical items sighted have</p>	<p>(i)Electrical equipment is not displaying current electrical safety testing tags; and (ii) the electronic maintenance register is not updated to reflect the status of the maintenance request.</p>	<p>Provide documented evidence that (i) testing and tagging of electrical items is current; and (ii) the electronic maintenance register is updated as maintenance requests are actioned.</p> <p>60 days</p>



		electrical test tags with the next test date recorded as due by 24 May 2014. Biomedical equipment and scales have current performance verification stickers in place.		
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.