

Cheviot Rest Home Limited

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 and Disability Auditing New Zealand 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:	Cheviot Rest Home Limited
Premises audited:	Cheviot Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 November 2014 End date: 20 November 2014
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	12

Executive summary of the audit

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
	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

General overview of the audit

Cheviot rest home provides rest home level care for up to 14 residents. On the day of the audit there were 12 residents. The owner/manager is an experienced aged care registered nurse and is supported by her staff and the local community. 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. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed a previous shortfall around the GP documenting the route of administration of medicines on medication charts.

This audit has identified improvements required around aspects of care planning and evaluations, activity care plans and medication competencies.

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.
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The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

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.		Standards applicable to this service fully attained.
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Cheviot Rest Home has an organisational philosophy, which includes a vision, mission statement and strategic objectives.

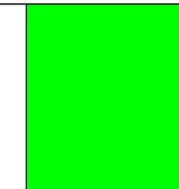
The owner/manager has owned the facility for the past fourteen years. A new registered nurse has been employed and has been at the service for five months. The registered nurse provides clinical support for the service. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Staffing levels are safe and appropriate.

Continuum of service delivery

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 low risk.
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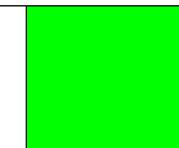
Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to risk assessments and care planning documentation. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration are trained however there is an improvement required around medication competencies being completed. Resident medications are reviewed by the residents' general practitioner at least three monthly. A range of activities are available in both rest home and dementia units and rest home residents provide feedback on the programme. An improvement is required around reviewing of activity care plans. Cheviot Rest Home has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded.

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.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness which expires 1 July 2015.

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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The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint or enablers. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually.

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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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)
Standards	0	12	0	4	0	0	0
Criteria	0	34	0	5	0	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)
Standards	0	0	0	0	0
Criteria	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.</p> <p>Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service.</p> <p>Interviews with six residents and two relatives are familiar with the complaints procedure and state any concerns or complaints are addressed.</p> <p>The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been six lodged complaints in 2013 and one for 2014. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies are in place relating to open disclosure. Six residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>A sample of incident reports reviewed, and associated resident files, evidences recording of family notification. Two relatives interviewed confirm they are notified of any changes in their family member's health status. The owner/manager and registered nurse can identify the processes that are in place to support family being kept informed.</p> <p>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.</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p> <p>D11.3 The information pack is available in large print and is read to sight-impaired residents.</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>The manager of Cheviot rest home is the owner/manager who is a registered nurse. The service has employed a registered nurse who works one day per week and covers on call and when the owner manager is away. The rest home provides care for up to 14 rest home residents with 12 residents residing in the facility on the day of audit. The service has a current strategic plan and quality plan for 2014. The quality programme is managed by the owner/manager and the registered nurse. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. Quality improvements are discussed at monthly staff meetings which incorporate the agenda items of health and safety, restraint and infection control. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The service benchmarks its performance as part of the external quality programme.</p>

		<p>D15.3d: The owner/manager (RN) has maintained at least eight hours annually of professional development activities related to managing a rest home including managers training days on quality data, attending residential care study days, InterRAI training, assessor workshop for aged care education programme, gerontology study days and professional boundaries training. The manager meets with other managers in the area.</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>FA</p>	<p>The service has a strategic plan and quality risk management plan that are implemented. Progress with the quality plan is monitored through the monthly staff/quality meetings. The quality/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. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Cheviot rest home's commitment to on-going quality improvement. Discussions with the owner/manager (RN), registered nurse and three caregivers confirm their involvement in the quality programme. Quality goals for 2014 included but not limited to reducing falls, reducing skin tears, reducing medication errors, improving end of life care, purchase of furniture and equipment and to have all residents assessed through InterRAI. Resident/relative meetings take place two monthly (10 November 2014). There is a six monthly resident/relative newsletter produced. There is an internal audit schedule 2014 and internal audits are completed as per the audit schedule. Audits include: cleaning, laundry, food service, admission procedures, infection control, care plans, complaints, medication management, personal privacy and safety, continence, cultural safety and spiritual beliefs, wound management, staff training and informed consent. 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 April 2014.</p> <p>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.</p> <p>There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There</p>

		<p>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.</p> <p>D5.4 The service has policies/ procedures to support service delivery; Policies and procedures align with the client care plans. Policies are provided by an external provider who provides the service with regular updates. The owner/manager is responsible for policy review.</p> <p>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.</p> <p>D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management</p> <p>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.</p> <p>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 owner/manager (RN) who completes the follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly quality/staff meetings. A family survey conducted in May 2014 evidences that families are over all very satisfied with the service.</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>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the external benchmarking programme and this is able to be used for comparative purposes with other similar services.</p> <p>Three incident forms were sampled from November 2014. Four medication incidents were also reviewed for October 2014. All show the form has been fully completed and reviewed by a registered nurse. All have on-going review and where appropriate actions to prevent recurrence completed by owner/manager.</p> <p>Staff/quality meeting minutes (23 October 2014) include a comprehensive analysis</p>

		<p>of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data collected.</p> <p>The monthly reports provided to staff via meetings and staff notice boards include benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents.</p> <p>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.</p> <p>D19.3c Discussions with the owner/manager (RN) and registered nurse confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.</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>FA</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including RN, pharmacist and GPs is kept.</p> <p>There are human resources policies folder including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (two activities coordinator, the registered nurse and two caregivers). Each folder has documentation arranged under personal information, correspondence, agreement, education and appraisals.</p> <p>An orientation programme is in place that provides new staff with relevant information for safe work practice. This was described by staff and records are kept. A buddy system supports new staff. There are orientation books that include checklists for completion in files reviewed.</p> <p>There is a documented in-service programme for education and the nurse manager is responsible for the development of the programme. Competencies are identified and completed (# link 1.3.12.3). Caregivers are encouraged and supported to undertake external education. ACE training is supported.</p> <p>The owner/manager interviewed confirmed that 80% of staff have completed the national certificate in the support of the older person. The owner/manager who is a registered nurse attends external training including conferences, seminars and sessions provided by the local DHB. The owner/manager has attended education</p>

		and training sessions from external providers in 2014. Education provided in 2014 and to date so far includes infection prevention and control, medication, pain management, skin tears, skin management, delirium, dementia, insulin, complaints, open disclosure, fire evacuation and first aid training for all staff February 2014. Opportunistic training is completed by the owner /manager and registered nurse for staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing levels and skill mix policy in place. Sufficient staff are rostered on to manage the care requirements of the rest home residents. At least one staff rostered on at any one time with one staff on-call. The owner/manager (RN) provides first on call. The registered nurse is also available on call. Advised that extra staff can be called on for increased resident requirements. Roster includes: one caregiver works 0700 - 13.00; one caregiver works 08.30-1530: one care giver 1500 - 2230; one care giver 1830 -2100; one care giver 2230 - 0730. The activities are provided for 12.5 hours per week; cleaner 1000-1200 Monday, Wednesday and Friday. Interviews with three caregivers, six residents and two family members identify that staffing is adequate to meet the needs of residents.
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	There are medication management policies and procedures in place that follow recognised standards and guidelines for safe medicine practice. The pharmacy deliver medico blister packs four weekly and any pharmaceuticals required at any other time. The owner/manager (RN) or registered nurse checks medications on delivery against the drug chart and signs the signing sheet to indicate the medications have been checked. The pharmacy carries out monthly reviews in consultation with the GP, the owner/manager and/or the registered nurse and re-print the medication drug charts. The drug charts are reviewed and signed by the GP at least three monthly. The drug charts are pharmacy generated. The medication chart has been reviewed to include a section on the drug charts for the GP to record route of administration. Ten out of ten drug charts sampled have the route of medications charted. This was a previous audit finding that has now been addressed. Each individual medication prescribed is signed by the GP. Medication discontinued is dated and signed by the GP. There is photo identification for every drug chart. Medications are kept in a locked cupboard in the manager's office. There is no medication fridge. Any medications requiring refrigeration are kept in a separate

		<p>sealed box in kitchen fridge. The temperature is recorded weekly and staff can visually check the temperature at any time. There is a specimen signature list. There are no residents who are self-medicating. Eye drops are dated on opening.</p> <p>Caregivers or the registered nurses administer medications. All medication persons undertake a medication competency assessment however this has not been completed annually. The owner/manager and the registered nurse have not completed medication competencies. Medication education has been completed in June and October 2014. The owner/manager (RN) has completed syringe driver competency. The registered nurse and the owner/manager have completed training with each staff member on medication management however competency has not been documented.</p> <p>The registered nurse and one caregiver were observed to safely and correctly administration medications.</p> <p>D16.5.e.i.2; Ten medication charts sampled had been reviewed and signed by the GP at least three monthly. Medication charts are generated from the pharmacy at least monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>One caregiver carries out the cooking duties and prepares the hot midday meal and gets the dinner ready for the afternoon caregiver to heat and serve. Night staff complete some food preparation. There is a five week summer and winter menu. The daily menu is written up on a board in the dining room. A menu appraisal was carried out by the dietitian 2013. A daily log book is maintained in the kitchen for any variations to the menu and memos for oncoming staff regarding the food service. Diabetic diets, modified diets, dislikes, religious and cultural beliefs are accommodated. Specialised crockery and utensils are available if required to promote independence with meals. Resident nutritional profiles are held in the kitchen. Weekly hot food temperatures are recorded on Sundays roast meat meals. There are meals on wheels that go out to the community. Weekly fridge and freezer temperatures are recorded and all within the acceptable ranges. All perishable foods in the fridge were date labelled. Staff were observed to wear appropriate protective clothing when preparing food. Chemicals are supplied by Ecolab and all chemicals are kept in a locked cupboard. There is a product chart and safety data sheets available. Ecolab conduct quality controls checks in the kitchen and provide staff education on-site. The kitchen space is adequate and there are two stand-alone fridges, one chest freezer and two stand-alone freezers. There is an electric</p>

		<p>oven and a dishwasher. There is a fire extinguisher and fire blanket available. The residents meetings give residents an opportunity to feedback on the service. Six residents interviewed were very satisfied with the meals. Internal audits are conducted.</p> <p>D19.2 All staff who carry out kitchen duties have been trained in safe food handling. Education on food safety was conducted in 2013.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Cheviot Rest Home provides services for residents requiring rest home level of care. Individualized care plans are completed. The three caregivers and registered nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including sling hoist, wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment. Mobility aids required to meet the mobility needs and safety of residents assessed needs were available and referrals made to the physiotherapist as needed. There is a falls risk assessment and support strategies checklist used in conjunction with the Coombes falls risk tool.</p> <p>Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.</p> <p>There are currently no wounds and no pressure areas. Evidence of wound care assessment, treatment plan and evaluation was sighted following a skin tear which has now healed. There is a wound care policy and access to a wound care nurse and specialists as required. Skin tears and skin management training has been completed in August 2014. Wound management and pressure area training has been completed in September 2014.</p> <p>Six residents and two family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs.</p> <p>Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>The owner/manager is a registered nurse and there is one other registered nurse employed by the service. A record of all health practitioners practicing certificates is kept.</p> <p>Needs are assessed using pre admission documentation; doctors notes, and the</p>

		<p>assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals (# link 1.3.8.2). Care plans have not always been updated to reflect intervention changes following review or change in health status as evidenced in three of five files reviewed. Care delivery is recorded and evaluated by caregivers or registered nurses in the progress notes at least at least daily (evidenced in all five residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral.</p> <p>During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.</p> <p>Short term care plans are in use for changes in health status (# link 1.3.8.3).</p> <p>D18.3 and 4 Dressing supplies and a range of products are available.</p> <p>Weight is monitored monthly. There is access to a dietitian as required.</p> <p>The geriatrician visits the service frequently and as requested.</p> <p>Cheviot rest home have implemented the Liverpool Care Pathway for end of life and there is support from the locum GP's and Nurse Maude are readily accessible.</p>
<p>Standard 1.3.7: Planned Activities</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>	<p>PA Low</p>	<p>The activity officer has been in the role for 18 months and works 1.30pm-3pm four days per week. There is also another staff member that delivers the activity programme one day per week. Both the activity officers develop the activity programme and this is reviewed by the owner/ manager (RN). The activity officer co-ordinates the monthly programme and writes up monthly progress notes. On or soon after admission an activity assessment/social profile is completed and an activity plan developed by the main activity officer which is reviewed by the owner/manager or registered nurse.</p> <p>There are two volunteers who do flower arranging with the residents and play the piano and other community members visit to help with activities. Residents are encouraged to maintain their links with the community such as community functions, attending church, bowls, probus monthly luncheons at the hotel, flower shows, community library and agricultural events. The residents enjoy visits from the local pre-school, craft sessions, scrapbooking, painting, entertainment, DVD's, movement to music and music therapy. Families are invited to attend social functions and join the residents on outings. The programme is flexible to the needs and preferences of</p>

		<p>the group taking individual choice into account. The residents meeting (last held 10 November 2014) is an opportunity for residents to feedback on the programme and offer suggestions for entertainment, outings and activities. Six residents interviewed were very satisfied with the activities programme.</p> <p>Both activity officers are first aid trained.</p> <p>D16.5d Three of five resident files reviewed did not evidence that the individual activity plan is reviewed at the time of the care plan review (two residents have been at the service less than six months).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All initial care plans were developed by the owner manager or registered nurse on the day of admission and resident comprehensive long term care plans developed within three weeks of admission. Advised by the owner/manager RN and registered nurse that care plans and risk assessments are evaluated six monthly and signed by the registered nurse. There was no documented evidence that care plan evaluations and risk assessments were up to date in three of five resident files sampled (two residents have been at the service less than six months). Changes in health status do not always trigger an update on care plan (# link 1.3.6.1). Care plan reviews are signed as completed by a RN. GP's review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out her instructions, giving her full confidence in the management of the residents.</p> <p>Short term care plans used for short term needs are evaluated and either resolved or transferred to the long term care plan as an ongoing need. Short term care plans evidence included infections and skin tears. There was no evidence of short term care plan developed for three residents with documented (i) conjunctivitis, (ii) a painful knee and (iii) pneumonia.</p> <p>ARC: D16.3c: All initial care plans were evaluated by the owner/manager (RN) within three weeks of admission and the long term care plan developed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p>	<p>FA</p>	<p>The building has a current warrant of fitness that expires 1 July 2015.</p>

fit for their purpose.		
<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>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Cheviot 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/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the owner/manager (RN) and the registered nurse. The facility participates in an external benchmarking programme which provides comparative data with other sites of a similar size. Graphs and infection control reports are displayed for staff to read. There have been no outbreaks noted in the past two years.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Documented systems are in place to ensure the use of restraint is actively minimized. The owner/manager (RN) 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 restraint minimisation and safe practice, 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.</p> <p>Staff education on challenging behaviour management and restraint minimisation was conducted in September 2014. Restraint minimisation and safe practice audit was conducted in February 2014 with no corrective actions required.</p>

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 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	Registered nurse and caregivers administer medications. All medication persons undertake a medication competency assessment.	Staff administering medication including the owner/manager and the registered nurse have not completed medication competency annually.	<p>Ensure that all staff administering medication completes annual medication competencies.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals (# link 1.3.8.2).	(i) One resident with weight loss and dietitian recommendations does not evidence interventions updated in the resident's long term care plan. (ii) One resident that requires the use of a hoist does not have evidence of hoist interventions updated in the resident's long term care plan. (iii) One resident who wanders and has fallen does not have evidence of updated interventions	(i), (ii) and (iii) Ensure that all interventions are updated in the resident's long term care plan to support identified resident health needs.

			in the resident's long term care plan.	60 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>On or soon after admission an activity assessment/social profile is completed and an activity plan developed by the main activity officer who is reviewed by the owner/manager or registered nurse. Residents are encouraged to maintain their links with the community such as community functions, attending church, bowls, probus monthly luncheons at the hotel, flower shows, community library and agricultural events. The residents enjoy visits from the local pre-school, craft sessions, scrapbooking, painting, entertainment, DVD's, movement to music and music therapy. Families are invited to attend social functions and join the residents on outings. The programme is flexible to the needs and preferences of the group taking individual choice into account.</p>	<p>Three of five resident files reviewed did not evidence that the individual activity plan is reviewed at the time of the care plan review (two residents have been at the service less than six months).</p>	<p>Ensure that activity care plans are reviewed at the long term care plan review</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>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.</p>	PA Low	<p>All initial care plans were developed by the owner manager or registered nurse on the day of admission and resident comprehensive long term care plans developed within three weeks of admission. Advised by the owner/manager RN and registered nurse that care plans and risk assessment are evaluated six monthly and signed by the registered nurse.</p>	<p>There was no documented evidence that care plan evaluations and risk assessments were up to date in three of five resident files sampled (two residents have been at the service less than six months).</p>	<p>Ensure that residents long term care plans are reviewed at least six monthly or sooner to support residents identified needs.</p> <p>60 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Low</p>	<p>Short term care plans used for short term needs are evaluated and either resolved or transferred to the long term care plan as an ongoing need. Short term care plans evidence included infections and skin tears</p>	<p>There was no evidence of short term care plan developed for three residents with documented (i) conjunctivitis, (ii) a painful knee and (iii) pneumonia.</p>	<p>Ensure that short term care plans are developed to support residents change in identified health care needs.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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.

No data to display

End of the report.