The Ultimate Care Group Limited - Greytown Lifecare

Current Status: 28 July 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Greytown Lifecare is a part of the Ultimate Care Group (UCG). UCG is owned by Windhaven Investments who have a chief executive officer (CEO) to manage an executive team that supports their 16 facilities.

Greytown Lifecare is an aged care residential facility located in the small rural town of Greytown in the Wairarapa. It has a district health board (DHB) contract to provide rest home and hospital level care. The facility has a total of 33 beds. Three are vacant on the day of audit. Fifteen residents are currently receiving hospital level care while the remaining 15 residents are receiving rest home level care.

The facility is fully staffed with 38 people employed by the facility. A full time manager has responsibility for day to day management with a clinical team leader who has clinical oversight responsibilities. A national team supports the facility with a regional manager having oversight of the facility.

Nine of the ten previous corrective actions have been addressed with improvements in the areas of quality and risk management, adverse event reporting and staff training systems. Timeframes for planning and responses to changes in progress are reflected in service delivery process improvements along with the majority of the required improvements in medication management systems.

During the surveillance audit, areas requiring improvement are identified related to the supervision of medication being taken by residents and the recording in the controlled drugs register.

Audit Summary as at 28 July 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 28 July 2014

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

Organisational Management as at 28 July 2014

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

Continuum of Service Delivery as at 28 July 2014

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

Safe and Appropriate Environment as at 28 July 2014

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

Restraint Minimisation and Safe Practice as at 28 July 2014

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

Infection Prevention and Control as at 28 July 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	The Ultimate Care Group Limited
Certificate name:	The Ultimate Care Group Limited - Greytown Lifecare

Designated Auditing Agency:	The DAA Group Limited

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

Proposed changes to current services (if any):
Nil

Total beds occupied across all premises included in the audit on the first day of the audit:	30

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	4
Other Auditors	XXXXX	**Total hours on site**	8	**Total hours off site**	4
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26

Number of residents interviewed	4	Number of staff interviewed	7	Number of managers interviewed	2
Number of residents' records reviewed	4	Number of staff records reviewed	4	Total number of managers (headcount)	2
Number of medication records reviewed	8	Total number of staff (headcount)	38	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXX, Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Wednesday, 20 August 2014

Executive Summary of Audit

General Overview

Greytown Lifecare is a part of the Ultimate Care Group (UCG). UCG is owned by Windhaven Investments, who have a chief executive officer (CEO) to manage an executive team who support their 16 facilities. Greytown Lifecare is an aged care residential facility located in the small rural town of Greytown in the Wairarapa. It holds a district health board (DHB) contract to provide rest home and hospital level care. It has a total of 33 beds. Three are vacant on the day of audit. Fifteen current residents are receiving hospital level care while the remaining 15 residents are receiving rest home level care. The facility is fully staffed with 38 people employed by the facility. A full time manager has responsibility for day to day management with a clinical team leader who has clinical oversight responsibilities. A national team supports the facility with a regional manager having oversight of the facility. Nine of the ten previous corrective actions have been addressed with improvements the area of quality and risk management, adverse event reporting and staff training systems. Timeframes for planning and responses to changes in progress are reflected in service delivery process improvements along with the majority of the required improvements in medication management systems being achieved.

During the surveillance audit areas requiring improvement are identified related to the supervision of medication being taken by residents and the recording in the controlled drugs register.

Outcome 1.1: Consumer Rights

Greytown Lifecare provides an environment conducive to open disclosure. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Relatives and residents feel well informed about the care and services provided at Lifecare.

All residents are given a copy of the complaint form on admission and forms are available in the facility at all times. The manager is responsible for investigating and managing complaints. All complaints are recorded in the complaint register. The complaint/concern policy meets the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights.

Outcome 1.2: Organisational Management

Greytown Lifecare is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a clinical team leader and the regional manager. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place. There is a quality improvement plan which includes an annual calendar of internal audit activity, including monitoring of the activities programme, administration functions, human resources, health and safety, infection control, medication, and residents' care. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and ensure a continuous quality improvement occurs.

The staff report feeling well supported by the manager and the registered nurses (RNs). A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A documented training programme is in place to maintain competence of all staff.

Outcome 1.3: Continuum of Service Delivery

There is evidence that the residents of Greytown Lifecare have their needs assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. A previous required improvement has been addressed with all resident files sighted providing evidence that needs, goals and outcomes are identified and reviewed in a timely manner and on a regular basis. Where progress is different to that expected, changes are initiated.

An activities programme, that includes a diverse number of activities and involvement with the wider community, is enjoyed by residents. Residents participate in events organised by other residential aged care homes and the community.

Well defined medicine policies and procedures guide practice, however not all practices are consistent with these documents. There is a previous required improvement which is ongoing, with issues of concern evident around ongoing medication errors and the administration of antibiotics. The previous improvement required around residents self-administering medication has been addressed as has the level of detail required for medicine management information and medicine reviews.

Menus are reviewed by a dietitian. A previous required improvement around residents who have additional or modified nutritional requirements has been addressed with any special dietary requirements and need for feeding assistance or modified equipment being recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided. Improvements have been made to the onsite kitchen in relation to aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complying with current legislation and guidelines. This addresses a previous area requiring improvement.

Outcome 1.4: Safe and Appropriate Environment

The facility has a current building warrant of fitness. Regular emergency evacuation drills are completed under the supervision of the local chief fire officer. The most recent was completed on 7 July 2014.

Outcome 2: Restraint Minimisation and Safe Practice

The use of enablers is for safety of residents in response to individual requests from residents. Those currently in use are monitored and reviewed regularly. The staff have regular training in restraint minimisation and the safe use of enablers.

Outcome 3: Infection Prevention and Control

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported and attended to through all levels of the organisation, including governance.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	0	1	0	0
Criteria	0	40	0	0	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	There is evidence medicine management protocols are not being followed with regards to dispensing and administrating medications resulting in recurrent medication errors.	Provide evidence and demonstrate compliance with the current protocols to ensure safe and appropriate medicine management.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Greytown Lifecare provides an environment conducive to open disclosure. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided as a part of the in-service education programme. The last education session was provided in March 2014. Staff confirm they understand that relatives and residents must be informed of any changes in care provision. Four family members and four residents interviewed confirm they are kept well informed. Two incidents with residents are sighted and both document relatives being informed in a timely way.

There are no residents that require interpreting services; however, the management is aware of how to access interpreters if this service should be required.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All residents are given a copy of the complaint form on admission and forms are available in the facility at all times. The manager is responsible for investigating and managing complaints. All complaints are recorded in the complaint register. The complaint/concern policy meets the requirements of Right 10 of the Code. This is sighted with a total of five complaints having been received so far this year. The issues raised are low level with no serious complaints being lodged. These have all been responded appropriately to and have been resolved within the required timeframes. Every complaint is then entered into the electronic quality system (GOSH) and becomes a part of the quality process.

A relative who has supported his mother with her entry to the service two weeks prior to the audit reports he has received all relevant information about the complaints process and would feel very comfortable making a complaint should that ever be necessary.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility is owned by Windhaven Investments which trades under the Ultimate Care Group name. It has a CEO and one regional manager to provide relevant support to each of the 16 facilities in the group. Each facility has its own business plan which is written by the manager of the facility and approved by the regional operational manager. The vision and goals of the organisation are on display at the main entrance and these are integrated into the planning for each facility.

The manager, who is a registered nurse (RN), has been with the organisation in the role for four years and has had 25 years experience in the aged care sector including management experience.

Reports are submitted to head office weekly and these are reviewed by the regional manager and the senior management team. The last report is sighted and it contains information on occupancy rates, staffing, resident enquiries and discharges with updates on previous issues raised and any new ones that require responses. The manager reports she has regular meetings with the regional manager who is supportive and available to assist as required. A business plan for the facility for 2014-15 details planned goals and action for the year. The plan also includes planning for new quality improvement initiatives identified.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a detailed quality and risk management plan which is reviewed annually. The current plan is 2013 – 2014. The organisation's quality policy states they will provide 'service excellence without compromise' through all levels of our organisation. The plan details the responsibilities for quality in each facility, specifically the facility manager and the senior clinical staff. The manager and clinical services manager will run the quality improvement programme in each facility. Feedback from residents / family/whanau and staff will be invited regularly throughout the year. There is a clinical advisory group (CAG) which includes consultation with the regional operations manager and each facility manager. The CAG is made up of the executive team, audit & compliance manager, HR manager, project manager and the southern and northern operations managers. They meet six weekly and all managers receive updates and any changes to policies are sent.

A range of quality indicators are being monitored in 2013-14; these include clinical indicators (assessments, falls, pressure ulcers, skin wounds, bruises, behavioural incidents, infections, drug errors, near misses / incidents / accidents, weight loss and sentinel events), as well as non-clinical indicators (complaints, property/security / emergency incidents, staff injuries, in-service training and attendance, staff appraisals, induction and orientation of new staff, entry and exit numbers, agency hours).

All incidents / accidents, complaints, satisfaction surveys, internal audits, infections, medication errors, health and safety, falls and the range of residents and staffing issues inform the quality system at both national and local level. All incidents are entered into the 'GOSH' system and alerts are sent to the regional and quality managers.

The manager keeps a monthly record of the numbers of incidents against the quality indicators and analysis of these indicators is completed and then presented to the facility quality committee which meets monthly. The quality committee consists of the manager, the clinical team leader, the health and safety officer, administrator, cook and two caregivers. The minutes of the 15 July 2014 record the reports from the audits done in the previous months, analysis of the quality indicators with any required corrective actions raised and monitoring and reporting from previous issues raised. All concerns and actions needed are communicated to staff at monthly staff meetings and minutes are available for all staff to see.

Audits are completed in June for maintenance, waste disposal, work area manuals and hot water temperatures.

The document control programme is managed by the administrator at the facility who is observed updating the policy manual with the latest versions that had been forwarded from the quality advisory group. Polices are reviewed two yearly, unless a need is identified for an earlier review.

The hazard register is reviewed during the audit and contains details of all current and potential risks with actions to minimise any consequences.

A previous corrective action for 1.2.3.8 is now fully attained. Corrective actions are now being raised in areas identified through the quality and risk management process. The manager confirms issues raised from internal audits, complaints, incidents and surveys are discussed at the monthly quality meetings. Decisions are made as to what actions are required to address these. A corrective action addressing falls for three residents is sighted with preventative measures being implemented and subsequent monitoring occurring. The corrective actions are signed off when completed by the manager.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Within the quality management system folder there is a detailed national policy on incident management and reporting. This states that all staff are responsible for reporting and responding to incidents and the place of analysis of incident data to assist in learning from them. There is a process for escalating serious harm incidents to head office and the audit compliance manager.

The incident reporting process is observed with an incident documented on the paper form being entered into the GOSH system to become a part of the monthly quality management cycle. The form includes documenting notification of family and medical professionals as required. A copy is also filed onto the resident's notes. Incidents are reported to the manager and the clincial team leader who review all incidents which are then discussed at the monthly quality meetings.

Analysis is completed and number entered into the quality indicator report which is sighted. For the month of June there were reductions in most of the recorded areas with the exception of two where the numbers have risen slightly. The number of infections reported had increased slightly and an analysis of this increase completed by the manager results in appropriate actions being currently implemented.

The manager confirms there is regional public health approved equipment on site for all cases that require isolation and the process for notification to authorities is clearly understood.

A previous corrective action for 1.2.4.3. is now fully attained. All incidents are now being recorded in the required format. These are analysed monthly to identify any opportunities for improving service delivery and identify and manage risk. Each incident is entered into the national register and this is observed in progress. A monthly analysis is completed by the manager and clinical team leader and these are discussed at the monthly quality meetings to determine what actions need to be taken to improve service delivery in the areas where the incidents have occurred.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All recruitment is currently managed by the manager. The manager reports that when a vacancy occurs, head office manage the initial advertising then the responsibility for shortlisting, interview, reference checks and police checks is done internally by the facility. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility also have relevant checks completed. The GPs' and the podiatrist's relevant qualifications are sighted. All annual practising certificates (APC)s are current.

Four of four staff files reviewed have all the required documentation including police checks, reference checks, job descriptions, individual employment contracts, CVs, orientation sheets and current performance appraisals. Also included are training records for all individuals. An orientation programme is completed by all new employees with a newly developed programme currently being implemented nationally. New staff are required to complete the orientation process within three months of commencing employment.

A comprehensive training programme is in place including in-service education, on line education and the ACE training programme. A previous corrective action for 1.2.7.5 now meets the requirements of the criterion with a system now in place to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to residents. The annual in service training plan is sighted and this includes training sessions held in infection prevention and control, falls prevention, the Code of Rights and advocacy, pressure and skin integrity, medication, back care restraint, incident and accident reporting, complaints and open disclosure. An on line training programme is also completed by staff that are unable to attend sessions and these are marked and entered into the training record system when completed. The manager holds a record of all training completed by staff and relevant certificates of completion are kept in individual staff files. These are sighted in four of four files reviewed. An honours board is on display in the main corridor which shows staff members' achievements in the ACE training programme. This is hoped to encourage more staff to complete this training. Eight caregivers are currently enrolled in doing this qualification.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A clearly documented protocol is used to ensure adequate coverage of staffing for all shifts. This describes the process for developing rosters in each facility which provides for 'staff designations and hours will be set according to the needs of the client groups, individuals and numbers'. This will take into consideration the age, gender, safety, response times, ethnic requirements, cultural mix and equipment availability (i.e. hoists and hydraulic beds). Staff hours will be set to ensure that they are sufficient to provide safe care in a timely manner. Clinical rosters are maintained by the manager and are prepared fortnightly in advance. The current rosters are sighted and evidence RN cover for all shifts with caregiver numbers to meet the current resident numbers and acuity. All RNs have current first aid certificates as does the diversional therapist. The manager reports no agency staff are required as there are sufficient staffing levels and a large casual pool to cover any absences.

The manager or the clinical team leader are on call at all times.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

The service provided by Greytown Lifecare is undertaken by suitably qualified providers and is developed with the resident and their family / whanau. A previous corrective action has been addressed with each stage of service provision in files (two of two rest home and two of two hospital) reviewed being within time frames that safely meets the needs of the resident.

The initial assessment process is undertaken by the registered nurse (RN) within 24 hours of admission and includes gathering data from the resident, their family / nominated representative and previous service providers. This informs the initial plan of care staff require to assist the residents to meet their immediate needs. A medical assessment of the resident is made by the resident's general practitioner (GP) within 24 hours of admission and a medical management plan is documented. This serves as the basis for care planning for up to three weeks.

Within three weeks of admission a long term care plan, based on the collection of comprehensive assessment data is completed by a RN. The long term care plan directs the care the resident requires to meet their needs and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift. Ongoing assessments, interventions and evaluation are completed and documented by the RN in consultation with the resident, family and allied professionals every three months or as residents' needs change, and ensures the appropriate care is provided and the residents' desired outcomes are being met.

Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident's medication is reviewed three monthly or as needs change and this is conducted by the GP as verified in eight of eight medication charts reviewed (refer 1.3.12.6).

Family contact is documented in the family contact record. Evidence of this is sighted in files reviewed and verified by resident (four of four) and family / whanau (three of three) interviews, as is evidence of satisfaction with care provided.

Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The registered nurses act as the resident's key worker and are responsible for planning, reviewing and overseeing all aspects of the resident's care.

Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the care to the resident. The care-on-line and in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. An onsite assessor assesses staff training. The cook has qualifications in food safety training. The contracted podiatrist provides services to the residents. The annual practising certificate (APCs) of staff requiring them is sighted.

A verbal handover by the RN occurs at the beginning of each shift to ensure all staff are familiar with the residents' needs.

Caregivers are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift.

Residents' notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Access to other health providers is evident in residents' files, where specialist input is required as sighted in files reviewed.

The ARRC contract requirements are met.

Tracer methodology one

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

Tracer methodology two

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The care and services at Greytown Lifecare are delivered in a safe and respectful manner. Files reviewed document residents' physical, social, spiritual and emotional needs with detailed interventions that ensure the care provided is consistent with the residents' assessed needs, desired outcomes and current best practice.

An interview with the GP has expressed satisfaction with the care provided to residents at Greytown Lifecare.

Interviews with residents and family / whanau members expressed satisfaction with the care provided.

There are sufficient supplies of equipment to meet the resident's needs and best practice guidelines (sighted).

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The activities programme at Greytown Lifecare is run by a qualified diversional therapist and a volunteer to assist as needed.

Within the first three weeks of admission to Greytown Lifecare residents are assessed to ascertain their needs, goals and appropriate activity requirements. The activities assessments and plans include the residents' preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.

Activities reflect ordinary patterns of life and include normal community activities (e.g. van outings once a week, shopping trips, visiting entertainers, visits to the local working man's club, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.

Monthly summary records the resident's response to the activities, level of interest and participation is recorded. Individual activity assessments, interventions and goals are evaluated, reviewed and updated every three months.

A residents' meeting is held monthly and meeting minutes evidence that the activities programme is discussed. The yearly resident / relative satisfaction survey also captures feedback on the activities programme and on outings which gives everybody the opportunity to have their opinions heard. Residents and family are satisfied with the activities offered.

The diversional therapist interviewed reports feedback is sought from residents during and after activities.

The Wairarapa District Health Board Advocate is available to residents if needed and has just presented an in-service education session to staff.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Evaluation of resident care at Greytown Lifecare is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if necessary. Family/whanau are kept informed of changes, as evidenced in family contact records in files reviewed.

Formal care plan evaluations are conducted at least three monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals, three monthly.

A previous corrective action has been addressed. In files reviewed, where progress is different from expected Greytown Lifecare responds by initiating changes to the care plan.

A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition

The RN undertakes and documents all care plan evaluations, at least every three months. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Evidence of evaluation is sighted in files reviewed. Resident and family interviews, verify they are included and informed of all care plan updates and changes.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The Medication Management Policy at Greytown Lifecare is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. However in the past four month there has been ongoing medication errors related to RNs not supervising residents taking medication and this is an area requiring corrective action.

Residents' medicines are received from the pharmacy in the Douglas Pharmaceuticals Medico Pak delivery system. All staff who administer medicines have current medication competencies (sighted). The staff interviewed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management, however one RN observed during a medication round removes the gelatine coating of an antibiotic to enable the contents to be minced with yoghurt, rather than requesting a suspension to be prescribed. This is an area requiring corrective action.

Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded. However there has been an error every month over the last four months relating to inaccurate recordings in the register. One of these related to a controlled drug being written up but found not to have been given to the resident and was resigned back in. This is an area requiring corrective action.

The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.

A previous corrective action around recorded medicine management information has been addressed. The medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.

There is one resident at Greytown Lifecare who self administers their medicines at the time of audit. The sighted assessment for self administration is in these files reviewed and meet the facility's policy; this previous corrective action request has been addressed.

The nurse manager monitors to ensure all staff who administer medications have current competencies. RNs are assessed for medication competency yearly and approved healthcare workers are certified as competent to check out medication (documentation sighted), under the direction of a RN.

Standing orders are not used at Greytown Lifecare.

The ARRC requirements are met

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

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

Attainment and Risk: PA Moderate

Evidence:

In reviewing medication incident records, there have been on-going medication errors. A number relate to RNs not supervising residents taking medication. In addition an error has occurred each month in the recording in the controlled drug register. One error is related to a controlled drug being written up and co-signed but not being given to the resident, so was re-signed back into the controlled drug register. Despite corrective actions being put in place errors continue to occur.

One RN is observed whilst doing a medication round. An antibiotic is given to a resident by breaking the gelatine coating and mixing the powder contents with yoghurt. A request for the doctor to prescribe the medication in liquid form had not been made.

Finding:

There is evidence medicine management protocols are not being followed with regards to dispensing and administrating medications resulting in recurrent medication errors.

Corrective Action:

Provide evidence and demonstrate compliance with the current protocols to ensure safe and appropriate medicine management.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food, fluid and nutritional requirements of the residents at Greytown Lifecare are provided in line with recognised nutritional guidelines for older people as verified by the dietitians documented assessment of the planned menu.

Training records verify the cook is trained in food and hygiene safety and management of residents' special dietary requirements.

Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the residents' recommended nutritional requirements.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. A previous corrective action required around consumers who have additional or modified nutritional requirements or special diets has been addressed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs are sighted. The cook has training in attending to special dietary needs and evidence of this is sighted.

Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed (as sighted and roster reviewed). The dining rooms are clean, warm, light and airy to enhance the eating experience

Food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered twice weekly depending on need and availability and meats and fish are ordered as required. A previous corrective action request around all aspects of foot procurement, production, preparation, storage, transportation, delivery and disposal has been addressed. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage.

Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date / time / contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The current building warrant of fitness is sighted. It has an expiry date of 30 June 2015.

ARRC requirement is met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There have been no alterations to the buildings since the last audit. An approved evacuation plan is in place dated 7 June 2007. The most recent evacuation drill was completed on 7 July 2014 and a report is on file completed by the local chief Fire Officer.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint coordinator in interview reports three residents are currently using enablers. These are in response to resident safety requests. In use are lap belts, bed rails and the use of lowered beds to manage risk of falls. Regular hourly monitoring is undertaken and records of these are sighted as completed as required.

The register is up to date with all residents who are using enablers having consents forms completed and approval from the families and the GP. All enabler use is reviewed three monthly with the GP. The facility process has been followed in all cases.

The policies and procedures for enabler use are well understood by the coordinator and staff training in restraint minimisation is a part of the annual training plan.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In line with the facility's infection control (IC) policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form. These are collated each month and analysed by the manager to identify any significant trends or possible causative factors. Data is presented to the quality meeting and staff meeting every month. Any actions required are implemented.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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