

# Presbyterian Support Central - Coombrae

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Current Status: 17 October 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification 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

Coombrae is part of the Presbyterian Support Central organisation. The facility provides rest home and dementia level care for up to 44 residents. There were 31 rest home and 12 dementia level care beds occupied at the time of audit.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified improvements required around the completion of internal audits, accident/incident forms, documentation around the resolution of complaints, clinical risk assessments, care planning, aspects of medication management and the safe storage of chemicals.

## Audit Summary as at 17 October 2013

Standards have been assessed and summarised below:

### Key

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

Indicator	Description	Definition
	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 17 October 2013

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.		Some standards applicable to this service partially attained and of low risk.
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### Organisational Management as at 17 October 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 17 October 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 17 October 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Restraint Minimisation and Safe Practice as at 17 October 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 17 October 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 17 October 2013

### Consumer Rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on notice boards. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents' and/or their family/whānau. Residents and family interviewed spoke very positively about care provided at PSC Coombrae. Complaints processes are implemented and complaints and concerns are managed.

There is an improvement required around documentation of complaints. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. There is a Maori Health Plan and the facility has developed a link with Kauwhata Marae.

### Organisational Management

Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and external benchmarking programme that is being implemented at PSC Coombrae. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. This audit identified improvements required around the completion of internal audits and incident/accident forms.

There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, monthly resident wellbeing meetings and six monthly family meetings.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

### **Continuum of Service Delivery**

The service has a policy for admission and entry for the rest home or dementia care unit. A service information pack is made available prior to entry or on admission to the resident and family/whanau.

Residents/relatives confirmed the admission process and the admission agreement are discussed with them. The Registered nurse is responsible for each stage of service provision. There is a requirement to provide evidence of resident and family/whanau involvement in the care planning process.

Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. There is an improvement required around the use of short term care plans for short term needs.

The residents' needs, interventions, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. There is an improvement required around pain assessments and the effective monitoring of pain relief. Resident files are integrated and include notes by the GP and allied health professionals.

There is a varied and interesting activity programme of activities, outings and entertainment that meets the group and individual interest, abilities and preferences. Community links are maintained and there are a number of volunteers who interact socially with the residents.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. There are improvements required to aspects of medicine management.

Food services and all meals are provided on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene

### **Safe and Appropriate Environment**

Coombrae rest home and dementia care facility has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. The environment is warm and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids.

Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction within the rest home.

There are communal and dining areas in the dementia care unit appropriate to meet the individual needs. There is a secure outdoor walking path and garden area for the dementia area. Other

outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care.

All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen, laundry and cleaners cupboard. There is an improvement required around the safe storage of chemicals in the dementia care unit. The cleaning service maintains a tidy, clean environment.

There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

### **Restraint Minimisation and Safe Practice**

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Staff receive training around maintaining a restraint free environment, including the management of behaviours that challenge.

### **Infection Prevention and Control**

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented for discussion. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings.

Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (a registered nurse) take overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations.

The service uses an external benchmarking programme for infection control. All surveillance activities are the responsibility of the infection control coordinator with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly.

# HealthCERT Aged Residential Care Audit Report (version 3.9)

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## 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

<b>Legal entity name:</b>	Presbyterian Support Central		
<b>Certificate name:</b>	Coombrae Rest Home		
<b>Designated Auditing Agency:</b>	Health & Disability Auditing NZ		
<b>Types of audit:</b>	Certification		
<b>Premises audited:</b>	Coombrae Rest Home		
<b>Services audited:</b>	Rest Home and Dementia		
<b>Dates of audit:</b>	<b>Start date:</b> 17 October 2013	<b>End date:</b> 18 October 2013	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			44

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed	6	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	34	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA 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	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA Auditing Agency has finished editing the document.	Yes

Dated Tuesday, 19 November 2013

## Executive Summary of Audit

### General Overview

Coombrae is part of the Presbyterian Support Central organisation. The facility provides rest home and dementia level care for up to 44 residents. There were 31 rest home and 12 dementia level care beds occupied at the time of audit. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified improvements required around the completion of internal audits, accident/incident forms, documentation around the resolution of complaints, clinical risk assessments, care planning, aspects of medication management and the safe storage of chemicals.

### Outcome 1.1: Consumer Rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on notice boards. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents' and/or their family/whānau. Residents and family interviewed spoke very positively about care provided at PSC Coombrae. Complaints processes are implemented and complaints and concerns are managed. There is an improvement required around documentation of complaints. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. There is a Maori Health Plan and the facility has developed a link with Kauwhata Marae.

### Outcome 1.2: Organisational Management

Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and external benchmarking programme that is being implemented at PSC Coombrae. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. This audit identified improvements required around the completion of internal audits and incident/accident forms. There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, monthly resident wellbeing meetings and six monthly family meetings.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

### Outcome 1.3: Continuum of Service Delivery

The service has a policy for admission and entry for the rest home or dementia care unit. A service information pack is made available prior to entry or on admission to the resident and family/whānau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them.

The Registered nurse is responsible for each stage of service provision. There is a requirement to provide evidence of resident/family/whanau involvement in the care planning process. Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. There is an improvement required around the use of short term care plans for short term needs.

The residents' needs, interventions, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. There is an improvement required around pain assessments and the effective monitoring of pain relief. Resident files are integrated and include notes by the GP and allied health professionals.

There is a varied and interesting activity programme of activities, outings and entertainment that meets the group and individual interest, abilities and preferences. Community links are maintained and there are a number of volunteers who interact socially with the residents.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. There are improvements required to aspects of medicine management.

Food services and all meals are provided on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene

#### **Outcome 1.4: Safe and Appropriate Environment**

PSC Coombrae rest home and dementia care facility is set within attractive grounds. The buildings have a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. The environment is warm and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction within the rest home. There are communal and dining areas in the dementia care unit appropriate to meet the individual needs. There is a secure outdoor walking path and garden area for the dementia area. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen, laundry and cleaners cupboard. There is an improvement required around the safe storage of chemicals in the dementia care unit. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

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

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Staff receive training around maintaining a restraint free environment, including the management of behaviours that challenge.

#### **Outcome 3: Infection Prevention and Control**

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented for discussion. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (a registered nurse) take overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control.

All surveillance activities are the responsibility of the infection control coordinator with assistance from the quality committee through the monthly quality

meeting. There is an online infection register in which all infections are documented monthly.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	38	0	5	2	0	0
<b>Criteria</b>	0	86	0	3	4	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	5	0	0
<b>Criteria</b>	0	0	0	0	0	8	0	0

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Four of six forms did not document if family had been contacted following the event. Contact with family was not evidenced documented in the resident files reviewed for these four incidents	Ensure family are informed following an event	90
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	The manager described meeting with each complainant to discuss the response letter and if resolution has been attained. However these meetings and their content were not documented.	Ensure that all actions taken are documented.	90
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Audits have not been completed as per the annual audit Schedule/planner. No audits were evidenced completed in May and June 2013. Completed audits did not consistently document the date or name of the person completing the audit.	Ensure internal audits are completed as per the audit schedule and are signed and dated by the person completing the audit.	60
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	i) There is no pain assessments in place for three of three dementia residents' files sampled for a) resident on controlled drugs pain relief, b) resident on regular analgesia, c) resident with chronic and new pain. There are no pain assessments in place for two of four resident files sampled for episodes of exacerbation of chronic pain. There are no pain intervention evaluation flow charts in place to monitor the effectiveness of pain relief.	Ensure that pain assessments are completed and pain intervention evaluation flow charts are utilized to monitor the effectiveness of pain relief administered.	30
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	<p>i) There are no short term care plans for two rest home and one dementia care resident with weight loss.</p> <p>ii) There is no evidence in three of four rest home resident files of resident/family/whanau involvement in the development of the care plan.</p> <p>iii) One dementia resident long term support plan did not include the wearing of hip protectors for prevention of injury. Resident is a high falls risk.</p>	<p>i) Ensure short term care plans are in place for short term/acute needs. ii) Provide evidence of resident/family/whanau involvement in the development of the care plan. Iii) ensure the long term support plan reflects current interventions.</p>	30
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	<p>i) There is one bottle of eye drops not dated on opening and two tubes of ointment in stock that has expired in the rest home medication room</p> <p>ii) Reconciliation of medication on transfer back to facility for one resident by the RN did not occur until the following morning when the RN came on duty resulting in an incorrect dose of one medication given.</p> <p>iii) Five out of 14 medication charts (one dementia care and four rest home) did not have indication for use of prn medications prescribed.</p>	i) Ensure all supplies are within their expiry date and all eye drops are dated on opening. Ii) Ensure reconciliation of medications occur for residents transferring back to the facility. iii) Ensure all prn medication have an indication for use prescribed on the medication chart.	30
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.1.1	Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Moderate	One unlocked kitchen cupboard in the dementia care unit contains a bottle of Ecolab heavy duty degreaser.	Ensure all chemicals in the dementia unit are stored locked cupboards.	7

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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<p>The service has available information on the Code of Health and Disability Services Consumers' Rights (COR) The Code was evident around the service. There is a resident rights policy in place.</p> <p>Code of Rights training was last completed in March 2013.</p> <p>Discussion with six health care assistants (three rest home and three dementia) all were aware of the COR and could describe the key principles and ways in which residents rights are acknowledged and incorporated in their day to day work such as obtaining informed consent,.</p> <p>D6, 2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&amp;D Commission. Eight family members and seven rest home residents interviewed confirmed that they were able to discuss the admission process with the manager prior to admission.</p>
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### Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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<b>Finding:</b>
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<b>Corrective Action:</b>
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<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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## Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

**Attainment and Risk:** FA

**Evidence:**

Residents' rights information is available, and large posters are displayed on the walls. The code of rights and advocacy pamphlets are located at the main reception.

D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a code of rights pamphlet, advocacy and H&D Commission information.

Service information provided to residents and/or their families/whanau prior to entry and this documentation is available in larger print format.

The interpreter service information is also available in the resident orientation pack.

The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents, such as on DVD, tape or video.

Staff will read information to residents and explain it (e.g. Informed consent and COR). Information is also given to next of kin or EPOA to read to or with the resident and discuss in private.

On entry to the service the manager or clinical manager discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Six rest home residents interviewed state they are well informed about the Code of Rights.

### Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

**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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

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

#### Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Residents rights information is available, and posters are displayed on the wall. The code of rights and advocacy pamphlets are located at the main foyer. D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a code of rights pamphlet, advocacy and H&D Commission information. Service information provided to residents and/or their families/whanau prior to entry and some of this documentation is in larger print format. The interpreter service information is also available in the resident orientation pack. The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents, such as on tape and video. On entry to the service the manager or care manager discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Seven rest home residents interviewed stated they were well informed about the CoR and the service provides an open-door policy for concerns/complaints. Information on complaints and compliments includes information on advocacy. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with six health care assistants described providing choice during daily cares. Interview with six rest home residents all stated staff provided a respectful service and were very

approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete education on abuse and neglect. Abuse and neglect training was provided in March 2012. There is a competency question included in the orientation programme around abuse and neglect which staff have completed. Discussions with residents and family members were positive about the care provided.

E4.1a Four families states that their family member was welcomed into the unit and personal pictures, familiar ornaments and bed linen were put in place to assist them to orientate to their new environment.

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified, PSC Coombrae implements the Eden and Spark of life philosophy which focuses on a person centred approach to care.

**Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)**

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

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

**Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)**

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

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

**Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

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

**Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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

**Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> A3.2: There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). The Presbyterian Support wide Maori Health plan that has been reviewed and updated through the Maori Health plan Wellington Group.

Cultural and spiritual practice is supported.

PSC Coombrae is currently reviewing the Maori Health Plan and two staff member who identify as Maori are involved in the review process.

The service is in the process of developing stronger links with the Kauwhata Marae and this also links with the Eden Philosophy.

The service identifies the need for staff to be trained in delivering appropriately cultural services. Cultural/treaty training has been provided in 2012.

There are currently no residents that identify as Maori.

Discussions with staff identify that have responded appropriately to the cultural needs of residents and their whānau.

Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. Staff identify that they are aware of how to obtain support so that they respond appropriately.

#### **Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)**

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

**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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

The organisation plans to ensure Māori receive services commensurate with their needs.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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

#### Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a spirituality, religion, faith and culture section in the care plan.</p> <p>D3.1g: The service provides a culturally appropriate service by identifying individual needs. There are currently no residents for whom English is not their first language.</p> <p>D4.1c: Care plans reviewed included the residents social, spiritual, cultural and recreational needs.</p> <p>Health care assistants interviewed were able to demonstrate an understanding of each residents cultural needs. There are multi-cultural staff available and interviews with six residents confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan</p> <p>Church services are held once a week. The local churches have a roster system to ensure that there is a service provided each week.</p> <p>The Roman Catholic church have a Eucharistic minister who provides a weekly communion service at the facility.</p>

### Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

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

### Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a code of ethics policy. Job descriptions include responsibilities of the position and ethics, advocacy &amp; legal issues. Enrolled nurse job descriptions include upholding legal and ethical standards and accountability and responsibility under the direction and supervision of registered nurses. The orientation booklet provided to staff on induction includes a section on professionalism and standards of conduct, harassment prevention policy and gifts. Understanding the code of conduct is signed as part of orientation. Completed orientation packages were sighted in six of six staff files sampled. Three education sessions on code of conduct/complaints/compliments/consumer service were completed in May 2013 with a total of 23 staff attending. Six health care assistants (three rest home and three from the dementia unit), two registered nurses and one enrolled nurse interviewed have a good understanding of professional boundaries. Six residents and eight family members (four rest home and four dementia) report that staff are always professional.</p>

### Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

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

### Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's ongoing progress around quality improvement. Policies and procedures cross-reference other policies and appropriate standards. RN's are encouraged and supported to continue education. There is a contracted Career force assessor that supports health care assistants to complete Career force or unit standards.</p> <p>The service has implemented a number of improvements since the previous audit. These include: a) Recreation programme now offered seven days a week, b) Nutritionally assessed full five week vegetarian menu now available with recipes, c) New food IT system that allows automatic food ordering and recipes to be printed with quantities linked to actual number of meals required. This minimises wastage from cooking too much and also ensures that there is enough food. On line recipes also allow relief cooks to have access to recipes for dishes they are unsure of. "Special week" menus and recipes are also available to substitute for the standard weeks, e.g. queen's anniversary week menu. There are a number of ethnic recipes e.g. Indian, Chinese available; d) Administrators manual developed and updated as required with all links to appropriate sites to ensure compliance with statutory changes are communicated and available when required, e) First version of managers manual completed and available on line, f) Cooks teleconferences started on a bi-monthly basis to review any issues around the menu, deliveries and to share ideas for resident involvement, g) Residents involved in recruitment of new staff, h) Clinical nurse specialist available to work with registered nurses who require additional support, i) Relatives and friends information booklet printed, j) Admission agreement reviewed and simplified so that residents and families can follow it, k) Environmental changes increase resident independence and autonomy e.g. kitchenettes set up with tea, coffee, l) Eden group increasing resident choice and autonomy – residents and families</p>

involved with the gardening, staff aware of the Eden Alternative and spend time without repercussion enjoying resident social needs, m) On line incident, medication error, complaints and infection registers with associated user manual and n) review of quality monitoring programme with new draft audit templates, o) improved external landscaping to the dementia unit, p) refurbishment of the Aroha resident lounge with resident input.

**Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)**

The service provides an environment that encourages good practice, which should include evidence-based practice.

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

**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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>Discussions with six rest home residents and eight family members all stated they were welcomed on entry and were given time and explanation about services. Resident meetings occur regularly and the Manager and has an open-door policy.</p> <p>A review of incident forms from September 2013 identified that relatives are not consistently informed in all cases following an event.</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.</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 that is not covered by the agreement.</p> <p>D16.4b Eight relatives stated that they are always informed when their family members health status changes.</p> <p>D 13.3 Seven files reviewed included completed admission agreements.</p> <p>Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</p>

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.

E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

#### **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:** PA Low

**Evidence:**

Eight family members interviewed confirmed they are informed of any incidents/accidents relating to their relative residing in the facility. The service documents incidents and accidents. The incident/accident form includes a designated area where contact with relatives/NOK is documented. Two of six incident accident forms documented contact with family had occurred following the event.

**Finding:**

Four of six forms did not document if family had been contacted following the event. Contact with family was not evidenced documented in the resident files reviewed for these four incidents

**Corrective Action:**

Ensure family are informed following an event

**Timeframe (days):** 90 (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 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

**Attainment and Risk:** FA

**Evidence:**

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Residents' Rights training was last provided March 2013. Interviews with six health care assistants identify that consents are sought in the delivery of personal cares and this is confirmed by eight residents interviewed. A sample of seven resident files all included signed consent forms for storage of personal information; to deliver care and support based on assessed needs; to take photograph for the purpose of health information; to have care delivered by supervised students; to be transported on outings; to involve family/whānau in assessment, planning and delivery of care. There is a resuscitation consent policy and a resuscitation consent form. Residents who are deemed competent to sign a resuscitation decision form indicate whether or not they wish to be resuscitated. A sample of seven resident files identified resuscitation consent forms were completed as appropriate.

D13.1: there were seven admission agreements sighted and all had been signed on the day of admission.

D3.1.d: Discussion with eight family identified that the service actively involves them in decisions that affect their relative's lives.

Six rest home residents interviewed confirmed they were consulted and given information to enable them to make informed decision regarding their care.

A resident survey completed in September 2013 evidenced that 92% of residents were satisfied with the medical care provided.

### **Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)**

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

**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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

**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 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

**Attainment and Risk:** FA

**Evidence:**

Client right to access advocacy and services is identified for residents and posted on the service notice-boards. The information identifies who the resident can contact to access advocacy services.

An Advocate chairs the residents meetings and provides a report to the manager.

The service at present does not have a Chaplain but is actively seeking to fill this vacant position.

Information provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information.

Staff was very aware of the right for advocacy and how to access and provide advocate information to residents if needed.

The welcome booklet includes a section around 'client advocacy.

D4.1d; Discussion with eight family members (four dementia, four rest home) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

### Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

**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 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

**Attainment and Risk:** FA

**Evidence:**

Family members and residents interviewed confirm that there are no restrictions made on visiting hours and family are made welcome.

D3.1h Discussion with six residents report that they are encouraged to be involved with the service and care.

Residents can access community services as they require. This is stated in the client information pack. Discussions with staff, residents and relatives identified that the service encourages residents to belong to community groups. One resident has been a member of Taonui Women's Institute (WI) since a young girl. She and three other ladies who expressed an interest are taken by staff in the facility van to the local meetings. The resident's family member confirmed at interview that she is able to continue to meet up with friends in the WI and participate in their meeting.

There is Interaction with local school and preschools with both groups visiting often. There are community volunteers, and community groups come and entertain.

D3.1.e Discussion with six health care assistants (HCAs), care manager and eight family members (four dementia and four rest homes) confirm that residents are supported and encouraged to remain involved in the community and external groups visit.

Resident/relative satisfaction survey completed evidenced 92.75% of residents were satisfied with the support provided to maintain community contact.

The facility is implementing the Spark of Life programme in the dementia unit to improve the provision of meaningful activities for residents.

### Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

**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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

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

### 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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. Verbal complaints are also included and actions and response are documented. Discussion with six residents and eight relatives confirmed they were provided with information on complaints and complaints forms. Complaint forms were visible for residents/relatives in various places around the facility.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry. There is a complaints folder and computer register that includes complaints verbal and written and includes sign-off. All complaints formal and informal are included on the complaints register and the PSC templates are used. The complaints folder and register has been kept up to date and all complaints are included on the register. Five complaints received in 2013 were traced. One was regarding standard of care, two around the food service and two regarding a resident entering another resident's room.</p> <p>Response letters to all complaints were evidenced to have been completed which included any outcome from investigations. The manager described meeting with each complainant to discuss the response and if the complaint has been resolved to the satisfaction of the complainant. However these meetings are not documented as occurring- Therefore there is an improvement required.</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the Dementia Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"><li>1. Minimising restraint.</li><li>2. Behaviour management.</li><li>3. Complaint policy.</li></ol>

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Responses to and the outcome of investigations around individual complaints are documented. The complaints register is current.
<b>Finding:</b> The manager described meeting with each complainant to discuss the response letter and if resolution has been attained. However these meetings and their content were not documented.
<b>Corrective Action:</b> Ensure that all actions taken are documented.
<b>Timeframe (days):</b> 90 (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:

Coombrae is part of the Presbyterian Support Central organisation. The facility provides rest home and dementia level care for up to 44 residents. There were 31 of 31 rest home and 12 of 13 dementia level care beds occupied at the time of audit. The service has established quality and risk management systems. The organisation has committed resources management including (but not limited to) and supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.

PSC Coombrae has a documented mission statement, vision, values, corporate commitment and older person's services goals.

There is a local risk management plan for 2013.

There is an Enliven Coombrae business plan that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals.

The manager is a registered nurse and midwife by background, with management experience (she is not a current health practitioner). The manager has been in her current role for nine months. PSC provides care manager orientation training and support at least every two months across the organisation. Enliven also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least eight hours annual professional development activities related to overseeing clinical care.

The manager has attended Four Quadrant Leadership education/training with PSC in March 2013.

ARC E2.1, The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

ARC, D17.3di (rest home), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

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

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

**Attainment and Risk:** FA

### Evidence:

### Finding:

### Corrective Action:

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

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

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

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

### Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> During a temporary absence, the care manager covers the manager's role. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QM programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

### Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service has a current business and a quality and risk management plan for 2013 -14.

The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to address shortcomings in previous certification audit.

Presbyterian Support Services Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at PSC Coombrae. There has been a review of the Quality Monitoring Programme with new draft audit templates introduced. The new templates have been in use since January 2013.

The manager provides a report to central office.

All staff are involved in quality improvements. The quality committee includes key staff from all areas of the service. Quality reports are provided to the committee by members of the quality committee and include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry monthly report, e) IC monthly report, f) restraint monthly report, g) clinical monthly report, h) managers monthly report, i) chaplains monthly report, j) activities monthly report, k) education monthly report, l) Eden monthly report, m) domestic/cleaning monthly report and n) administrative monthly report.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's ongoing progress around quality improvement.

The internal audit schedule has been combined to include QMP and QPS monitoring.

Policies and procedures cross-reference other policies and appropriate standards.

There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule

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.

There is a comprehensive IC Manual. Restraint policy and Health & Safety policy/procedures.

There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has improved and sessions evaluated.

There is a policy review date schedule, and terms of reference for the policy review group.

New/updated policies/procedures are included in the "What's New" manual for staff.

a) Monthly accident/incident/near miss reports are completed by the Clinical Manager that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is a new online database for recording accidents and incidents with medication errors reported separately.

Incidents and accidents are also reported to PSC clinical director monthly.

b) The service has linked the complaints process with its quality management system. This occurs through the QPS benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.

c) There is an IC register in which all infections are documented monthly. A monthly IC report is completed and provided to quality meeting. The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the newly introduced electronic database.

QPS data analysis includes: Competency testing for IC, Wound Infection Rate, skin infection rate, Infection rate, UTI's, Respiratory Tract Infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the three month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken during the year.

d) Health and safety monthly reports are completed for each service and presented to the quality committee. The report includes identification of hazards and accident/incident reporting and trends are identified.

e) The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. PSC Coombræ is currently restraint free.

The service completes an internal audit for each area which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. There is an improvement required around the completion of internal audits as per the audit schedule/planner. Meeting minutes and reports provided to the quality meeting have improved to the quality committee, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.

The service benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

A hazard register is established that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections.

Civil defense procedures are in place and supported by staff training.

Preventative maintenance audit is completed annually. There is a facility risk management plan 2013

The service documents risk or areas of concern and remedial action is identified as a result.

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

D19.2g Falls prevention strategies are in place such as falls risk assessment, physiotherapy assessment, sensor mats, exercise classes to promote balance and range of movement and walking aids.

D5.4 The service has the following policies/ procedures to support service delivery.

**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.

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

**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.

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

**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.

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

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

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

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Internal audits are completed and any corrective actions required are documented and signed off when completed. However there are gaps in the schedule.
<b>Finding:</b> Audits have not been completed as per the annual audit Schedule/planner. No audits were evidenced completed in May and June 2013. Completed audits did not consistently document the date or name of the person completing the audit.
<b>Corrective Action:</b> Ensure internal audits are completed as per the audit schedule and are signed and dated by the person completing the audit.
<b>Timeframe (days):</b> 60 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

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

**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.

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

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <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 service benchmarking programme and this is able to be used for comparative purposes with other similar services.</p> <p>Incident forms reviewed did not consistently document that family were contacted following an event (link 1.1.9.1). Six incident forms for September 2013 were reviewed which included two falls, two challenging behaviours, and two skin tears. All incident forms evidence follow up by a registered nurse.</p> <p>All have on-going review and where appropriate actions to prevent recurrence completed by the registered nurse or care manager.</p> <p>The fortnightly senior management meetings evidenced discussion around falls management and preventative measures to be implemented.</p> <p>Quality meeting minutes include a comprehensive analysis 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 the QPS 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</p>

corrective action to minimise and debriefing. There was evidence of the manager reporting a recent outbreak of gastroenteritis to the DHB and Public Health Department. Also the DHB and MOH were informed of an incident of flooding which occurred on the premises in September 2013.

**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.

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

**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.

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

## 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:**

A copy of practising certificates including RNs, EN's, pharmacists, the dietitian, the physiotherapist and GPs are kept.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (one recreation officer, one cook, one registered nurse and four health care assistants). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and appraisals.

A comprehensive 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.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book. Competencies are identified and completed.

Health care assistants are encouraged and supported to undertake external education. The education folder evidences that health care assistants have completed either ACE or Career force qualifications. Career force training is supported. The organisations policy is that after three months of employment all caregivers must be enrolled in Career force.

Training which occurred in 2013 included; chemical safety, in Feb and March with a total of 26 staff attending, Code of conduct /complaints/compliments and customer service – three sessions in May with a total of 23 staff attending, Medication management and challenging behaviour June 13 with 30 staff attending, Caring for hearing aids October, wound care July, Fire safety/drills in March and September and Manual handling in March.

Two staff training days have occurred in March and June 2013 which included the following topics; Infection control, challenging behaviours, medication management, quality and risk, Health and Safety.

D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for health care assistants/caregivers. PSC Coombræ has provided health care assistant and RN/EN compulsory training according to the framework.

E4.5f There is 10 health care assistants who work in the Rata Haven dementia unit. Nine have completed the required dementia standards; one is in the process of completing and has recently commenced employment.

**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.

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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:**

Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The roster is able to be changed in response to resident acuity. The QPS benchmarking quarterly report states that staff hours remain consistently above the mean. The facility manager works 32 hours per week and the care manager 40 hours per week. They provide 24/7 on call afterhours/weekend cover to support staff. There is an RN on duty on the morning shift seven days per week. The regional manager and manager advised that the facility is currently undertaking a review of the roster on consultation with staff.

### 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.

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

### Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The resident files are appropriate to the service type.</p> <p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure office. Support plans and notes are legible and where necessary signed (and dated) by the registered nurses. Policies contain service name. Resident records reviewed contain the name of resident and the person completing the form/entry. Stamps are utilised to determine some allied staff members.</p> <p>D7.1 Entries are legible, dates and signed by the relevant health care assistant, enrolled nurse or registered nurse including designation. Individual resident files kept demonstrate service integration with an allied health section that contains GP notes and the allied health professionals and Specialists involved in the care of the resident. There is also an allied health services assessment form with care requirements. For the resident Interdisciplinary assessment, all team members are named on the interdisciplinary assessment form.</p>

**Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)**

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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

**Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)**

All records pertaining to individual consumer service delivery are integrated.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Midcentral support links needs assessment coordination service (NASC) ensures all residents are assessed prior to entry for rest home or dementia level of care. A placement authority form is sent to the receiving facility. The Care Manager (CM) is responsible for the screening of residents to ensure entry has been approved. The RN forwards details to the CM to follow up potential enquiries. A pre-admission checklist ensures the potential resident and family receive a tour of the facility and are introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission. The information pack includes all relevant aspects of service and associated information such as the H&D Code of Rights and how to access advocacy. There is an admission procedure in place and admission documentation which includes resident and next of kin details. The CM and RN's (interviewed) are able

to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable time is arranged for admission. The CM/RN on duty completes all the admission documentation and relevant notifications of entry to the service. Signed admission agreements sighted. Six residents (rest home) and eight relatives (four dementia and four rest home) interviewed state they received all relevant information prior or on admission. The GP is notified of the new admission.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

E3.1 Two resident files were reviewed and all includes a needs assessment as requiring specialist dementia care

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

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

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

#### **Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)**

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member is informed of the

reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. There are no declined entry records.

### Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>D.16.2, 3, 4: The seven resident files sampled (four rest home, three dementia) identifies the RN completed an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support careplan. Seven resident files sampled identified that the longterm support plan is developed within three weeks. There is documented evidence of multidisciplinary reviews (MDT) held three monthly involving the resident/family/whanau, RN and care staff, recreational officer, medical (including medication review) and where applicable allied health input. The RN amends the long term support plan to reflect ongoing changes as part of the review process. Allied health professionals involved in the residents care are linked to the support careplan review such as, dietitian, physiotherapist, podiatrist, and community psychiatric nurse. All seven resident files sampled included a family/whanau communication form which documented discussions with family/whanau regarding changes to health, incidents, infections , MDT meetings,appointments, transfers to hospital and GP visits.</p> <p>D16.5e: Seven of seven resident files sampled identified that the GP had seen the resident within two working days. It was noted in the seven resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. Residents retain their own GP. There is a GP on call system from 6.30-</p>

10.30pm. Emergency treatment overnight is provided at the emergency department. The GP practice is available weekends from 7.30am -12.30pm and the City Doctors are on call for the remainder of the weekend. A locum GP interviewed stated the RN's are prompt in notifying him with any resident concerns and from his observations during his visits the residents receive good clinical care.

There is a 15 minute verbal handover period between the shifts to ensure staff are kept informed of residents health status and any significant events. There is a written handover sheet with significant information recorded. Handover period observed in the dementia unit between morning and afternoon healthcare assistants confirm information exchanged ensures continuity of all service. Progress notes are written at least daily. The day RN provides on call overnight with the weekend RN on call for the weekend.

A range of assessment tools is completed on admission and reviewed at least three monthly if applicable including (but not limited to); a) nutritional and fluid assessment b) falls risk (adapted from Morse) c) moving and handling assessment. d) braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment g) wound assessment

Four rest home and three dementia care resident files sampled.

Tracer Methodology

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

Tracer methodology: Rest home resident

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

### 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.

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

### Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment

needs, dietary needs, activities preferences, spiritual, cultural and social needs. Informed consents for storage and collection of information, delivery of care including procedures for wound, X-Ray and podiatry, photograph for ID and display, students delivering care, transport and outings, family involvement in assessment, careplans and evaluation of careplans, resuscitation. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment , first support plan and long term support care plan within the required timeframes. All resident files sampled (four rest home and three dementia care) evidenced an initial assessment and support care plan with reference to the information gathered on admission. Relatives (four hospital, four dementia care) and residents (six rest home) advised on interview that assessments were completed in the privacy of their single room. There is an improvement required around the use of risk assessment tools (link 1.3.4.2)

ARC E4.2; Three resident files reviewed included an individual assessment that included identifying diversionary, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

A range of assessment tools is available for use on admission if applicable including (but not limited to); a) nutritional assessment b) falls risk (adapted from Morse) c) moving and handling assessment. d) braden pressure area risk assessment, e) continence and bowel assessment, f) pain assessment, g) wound assessment.

**Finding:**

i) There is no pain assessments in place for three of three dementia residents' files sampled for a) resident on controlled drugs pain relief, b) resident on regular analgesia, c) resident with chronic and new pain. There are no pain assessments in place for two of four resident files sampled for episodes of exacerbation of chronic pain. There are no pain intervention evaluation flow charts in place to monitor the effectiveness of pain relief.

**Corrective Action:**

Ensure that pain assessments are completed and pain intervention evaluation flow charts are utilized to monitor the effectiveness of pain relief administered.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care as follows: hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest and sleep, communication (ability to use call bell, eyesight, memory, behaviour and mood), loneliness (companions), helplessness (socialisation), spirituality/faith and culture, medical (includes medication and pain management). Each individual page for category for care is signed and dated. The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), incident/accident and infection events summary and correspondence.

Short term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short term care plans are pre-printed for chest, urinary and ear infections, nutritional needs and wounds. Short term care plans sighted are for: gastroenteritis, skin infection, weight gain, cellulitis, chest infection. There is an improvement required around the use of short term care plans for short term needs (link 1.3.5.2).

Medical GP notes and allied health professional progress notes are evident in the seven residents integrated files sampled. Relatives (four rest home, four dementia care) interviewed are positive and complimentary about the staff, clinical and medical care provided. They confirm they are kept informed of any significant events and changes in health status.

E4.3 three resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status (link 1.3.5.2).

D16.3f; three out of three dementia resident files and one out of four rest home resident files reviewed identified that family were involved.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

- i) Short term careplans are available for use to document any changes in health needs with interventions, management and evaluations. One of three dementia resident files sampled did not have potential behaviours on assessment included into the long term support plan.
- ii) Three of the three dementia resident files evidenced family/whanau involvement in the development of the residents care plan. One of four rest home resident files reviewed evidenced resident/family/whanau involvement in the development of the care plan.
- iii) Six out of seven long term support care plans reflect the residents current needs.

<b>Finding:</b>
<ul style="list-style-type: none"> <li>i) There are no short term care plans for two rest home and one dementia care resident with weight loss.</li> <li>ii) There is no evidence in three of four rest home resident files of resident/family/whanau involvement in the development of the care plan.</li> <li>iii) One dementia resident long term support plan did not include the wearing of hip protectors for prevention of injury. Resident is a high falls risk.</li> </ul>
<b>Corrective Action:</b>
<ul style="list-style-type: none"> <li>i) Ensure short term care plans are in place for short term/acute needs.</li> <li>ii) Provide evidence of resident/family/whanau involvement in the development of the care plan.</li> <li>iii) ensure the long term support plan reflects current interventions.</li> </ul>
<b>Timeframe (days):</b> 30 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The six HCA's interviewed ( three dementia care , three rest home ) who work across all shifts and two RNs,one enrolled nurse and one CM stated that they have all the equipment referred to in support plans necessary to provide care, including hoists, pressure relieving mattresses and cushions, shower chairs, transfer belts, slidy sams, wheelchairs, gloves, aprons and masks. There is a "pool"of shared resources and equipment between the three PSC facilities in the area.</p> <p>D18.3 and 4 Dressing supplies are available and the hospital unit treatment rooms is well stocked. All staff report that there are adequate continence</p>

supplies and dressing supplies. Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound progress notes and short term care plan is in place for a chronic wound in the rest home wing. There is a recommendation to change the short term care plan to a chronic wound care plan and ensure photographs/tracings are taken on the initial assessment to monitor healing progress. There are short term care plans are used for minor wounds such as skin tears. There is evidence of district nursing referral and advice in care of the chronic wound. There are no wounds in the dementia care unit.

Continence products are available and resident files include a urinary continence assessment, bowel management, wounds and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and the CM and two RN's, one enrolled nurse 's interviewed could describe the referral process. Continence management in-services and wound management in-service have been provided. Palliative care is delivered with support from Arohanui Hospice community liaison nurses and specialists as required.

All residents admitted to the dementia unit are commenced on a behaviour log for the first three weeks to assist in the development of the long term support plan. Behaviour management is described in the long term support plan and includes types of behaviour, possible triggers and interventions. There are regular visits from the community psychiatrist nurse for elder health who liases with the psychogeriatrician.

A health status summary held in the residents record records any significant events, investigations, GP visits and outcomes.

The physiotherapist is involved in manual handling education and resident assessments as required by referral. The podiatrist visits six weekly.

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are two recreational officers who are both doing the Diversional therapy training. Both work part-time and provide a total of 32 hours a week and cover seven days a week. The recreational officers attend an annual peer support group meeting, monthly staff meeting and there is an Eden meeting fortnightly to review and plan the activity programme. There is core programme for the rest home and dementia care unit with combined activities and entertainment for the two units. The RN inform the recreational officers if there are any changes to a residents physical and cognitive wellbeing that may have an impact on their level of participation in the activity programme. There is a large recreational room whor these residentsere most activities take place. There are other smaller areas where individual activities can take place. There is an open plan dining room and separate lounge area in Ratahaven dementia care unit. Residents are encouraged to maintain links with community groups such as the RSA, primary schools, kindergarten, church groups and some residents are life members of the Toanui Institute. Volunteers are involved in the home assist with games, puzzles, housie, exercises, outings. The spark of life programme has commenced through the Sunshine club with positve feedback. The mens group have enjoy outings to model trains and car shows. Visitors to the home include musical entertainers, Parish Pooches, and manicurist. The facilty have a van with hoist. There are twice weekly outings and interhome visits, shopping and library visits are enjoyed. Activites in the dementia unit are based on individual abilties and include sensory stimulation and household tasks that include feeding the chooks, flower arrainging, setting tables, dishes, reminiscing and photo books. There are suggestions of activities on the programme for morning, afternoon and evening times. The recreational officers complete a resident life history with resident/family involvement, an activity assesssment within two weeks of admission and an individual activity plan that is reviewed at least six monthly. There is a schedule to co-ordinate the activity and long term support plan review at the same time. Feedback is received from the resident meeting and satisfaction surveys.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Three monthly MDT evaluations of the support plan are conducted and involve the GP, Clinical Mnaager, RN, HCA's, recreational officer, resident/family/whanau input . The written review form includes general recordings and weight, review of risk assessment tools, any issues to be discussed with the GP, medication chart review, medical examination conducted and GP monthly or three monthly visits indicated. The resident/family are notified of the review by letter and invited to attend. The long term support plan is amended with each review if there are changes. The family/whanau communication form has written evidence of discussion held with families regarding care plan reviews. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts were evidenced in use.  
D16.4a Care plans are evaluated three monthly more frequently when clinically indicated  
ARC D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)**

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; community psychiatric nurse for elder health, district nurse, speech language therapist, physiotherapist, podiatrist, General Practitioner, hospice . There is evidence of GP discussion with families re regarding referrals for treatment and options of care. D16.4c; the service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 discussions with registered nurses identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian and other allied health professionals.

**Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)**

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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

### Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The care manager and RN's interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation is sighted in residents record recently transferred back to the facility. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented

#### Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

**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:**

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals, douglas medico packs and collects the returns. Medications are checked and signed by an RN on delivery. Any discrepancies are fed back to the pharmacy. The RN's and senior health care assistants undergo a comprehensive medication competency annually and attend annual education. Arohanui hospice nurses and specialists support staff in caring for residents at end of life if requiring syringe driver medication. The rest home has the main medication room with supplies of pharmaceuticals and the controlled drug safe. The controlled drug stock is checked and signed in the register weekly. There is a six monthly pharmacy audit. The locked medication trolley for the dementia unit is kept in the nurses station. Other pharmaceuticals are kept in a locked cupboard within the nurses station. The medication fridges in both areas are monitored weekly. The RN carries out a weekly check on prn stock, oxygen cylinders and suction. There is one self medicating resident in the rest home. The resident has a medication competency assessment completed that is reviewed three monthly. There is evidence of staff monitoring of the self medicating residents medications. Standing orders are not used. HCA's are required to contact the RN prior to administering prn medications. The tea medication round observed in the dementia unit met medication safety standards.

14 resident medication charts (eight rest home, six dementia ) identified all charts had photo identification and allergies/adverse reactions noted. There is evidence of three monthly GP review of medications. The medication folder contains information and precautions for specific medications. Staff sign a signing register and the medication signing sheets are all correct. Prn medications have the times given documented.

D16.5.e.i. 2; 14 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed. There are improvements required around medication management.

#### 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:**

- i) There is a weekly checklist in place of prn medications. All eye drops in the dementia unit in use have been dated on opening.
- ii) Medications are checked on delivery by the RN on duty.
- iii) Nine of 14 medication charts have indication for use of prn medications prescribed.

**Finding:**

- i) There is one bottle of eye drops not dated on opening and two tubes of ointment in stock that has expired in the rest home medication room
- ii) Reconciliation of medication on transfer back to facility for one resident by the RN did not occur until the following morning when the RN came on duty resulting in an incorrect dose of one medication given.

iii) Five out of 14 medication charts (one dementia care and four rest home) did not have indication for use of prn medications prescribed.

**Corrective Action:**

i) Ensure all supplies are within their expiry date and all eye drops are dated on opening. ii) Ensure reconciliation of medications occur for residents transferring back to the facility. iii) Ensure all prn medication have an indication for use prescribed on the medication chart.

**Timeframe (days):** 30 (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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Food services policies and procedures manual is in place. There is a qualified cook on duty each day with an afternoon kitchenhand to serve tea. There is a five weekly summer and winter menu that is reviewed by the company dietitian. The company dietitian is readily available to the cook by email/phone for advice if required. The cooks receive peer support by teleconference monthly and when all the PSC cooks meet annually.</p> <p>All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a notice board and folder of residents likes/dislikes and alternative choices are offered. The cook is informed of dietary changes such as high calorie/high protein diets. Dietary needs are met including normal, soft, pureed, vegetarian. The main meal is midday lunch. The meals are served from the bain marie directly to the residents in the rest home dining room. Meals are delivered in the portable bain marie to the dementia unit. The cooks diary is a record of meals served and any menu or resident changes. Food temperatures are taken on the cooked food and on re-heating the tea meal. Fridge, freezer and chiller temperatures are recorded daily. All perishable foods are dated. Nutritional snacks and "finger foods" are delivered to the dementia unit including fruit, sandwiches, sweet biscuits, crackers and toppings, muffins and puddings. Temperature recordings of the dementia unit fridge sighted. The main kitchen area is well equipped with gas oven/hobs, combi oven, fridges and freezers. The dry goods are sealed, labelled and off the floor. Goods are rotated weekly with the delivery of food orders. Chemicals are provided by Ecolab. Safety data sheets are available and training provided as required. Chemicals are stored in a locked chemical cupboard. Personal protective equipment is readily available. There is a first aid kit in the kitchen. All equipment is checked regularly and there is a maintenance request book in the nurses station to log any non-urgent equipment concerns. There are screens on the windows and external door and there is a regular fly and cockroach pest management schedule in place. A weekly cleaner for the kitchen area ensures the cleaning schedule is maintained as sighted. The kitchen is locked after hours.</p> <p>The service receives feedback directly from the residents and from residents meetings. There is a resident food comment book in the dining room with positive comments on the meals There is good communication between the food services and the clinical areas and the cooks are informed of any</p>

residents dietary changes. Residents interviewed (six rest home) are happy with the choice and variety of meals.

E3.3f.: there is evidence that there is additional nutritious snacks available over 24 hours  
D19.2 staff have been trained in safe food handling, fire drills and other relevant inservice.

**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.

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

**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.

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

**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.

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

**Outcome 1.4: Safe and Appropriate Environment**

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

**Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)**

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemicals supplies are locked in the shed on delivery. The contracted maintenance person monitors the chemical use and distributes to the kitchen, cleaning and laundry areas for use. Chemicals are stored safely in the laundry and main kitchen, however one unlocked kitchen cupboard in the dementia care unit contains a bottle of Ecolab heavy duty degreaser. Ecolab supplies the chemicals, safety data sheets and chemical safety training as required. Budget waste management are contracted to regularly collect the skip bins monthly for general waste and recycling. Wheelie bins are used within the facility to collect general waste. Approved containers are used for the safe disposal of sharps. Staff have attended waste management and chemical safety education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</p>

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Chemicals are stored safely on delivery to the facility. Chemicals are stored safely in non-clinical service areas.
<b>Finding:</b> One unlocked kitchen cupboard in the dementia care unit contains a bottle of Ecolab heavy duty degreaser.
<b>Corrective Action:</b> Ensure all chemicals in the dementia unit are stored locked cupboards.
<b>Timeframe (days):</b> 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

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

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

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

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

**Attainment and Risk:** FA

### Evidence:

The building holds a current building warrant of fitness which expires 8 July 2014. The fire service evacuation approval letter is dated 9 October 2000.

The service is meeting the relevant requirements as identified by relevant legislation, standards and codes.

PSC Coombrae complex has a 31 bed rest home area divided into four wings Rata, Rimu, Nikau and Nikau extension and a 13 bed dementia care unit Rata Haven. Each rest home wing has a small kitchenette. Rata Haven has an open plan dining room area and separate lounge.

The physical environment with the wide corridors and spacious rooms allow easy access, movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas. There are communal dining and lounge areas and smaller areas for private meetings with family/visitors or allied health professionals. There is a large recreational room.

The maintenance person contracted through horticultural services carries out the daily maintenance request and planned maintenance schedules for internal and external building maintenance. Monthly checks include emergency lighting, check of trolleys and emergency generators. The environmental and clinical equipment have current warrant of fitness test and tags. The facility van with hoist has a current warrant of fitness and registration.

The hot water temperature in resident areas is carried out monthly (sighted) and complies with regulations. There is adequate storage areas for hoist, wheelchairs, products and other equipment.

The grounds are tidy, well maintained and able to be accessed safely. Outdoor areas have seating and umbrellas for shade. There are raised garden areas and a bird aviary. Rata Haven dementia care unit has safe outdoor areas, seating and shade, raised gardens, chook run, and a circular walking path. There is a plan to extend to extend the walkway. There is secure entry and access to the dementia care unit.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, one hoists, wheelchairs, heel protectors, transferring aids, walking frames, weighing scales.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

### Evidence:

### Finding:

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

One rest home bedroom has a full ensuite and one has a toilet only. All other rooms are single with hand basins. There are adequate numbers of communal toilets/showers each wing. The bathroom and toilets have appropriate flooring and handrails. There are vacant/occupied slide signs. All bedrooms in the dementia unit have hand basins. There are adequate numbers of communal toilet/shower facilities. Privacy curtains are in place in toilets and shower rooms.

#### Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

**Attainment and Risk:** FA

**Evidence:**

All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. The bedrooms in the dementia units have ordinary beds and adequate space for residents to move about safely with mobility aids if required. The rooms are uncluttered with minimal furnishings.

Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed (six rest home) confirm their bedrooms are spacious and they can personalise them as desired. Relatives interviewed (four rest home and four dementia) state they are happy with the bedrooms.

**Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuver with the assistance of their aid within their personal space/bed area.

**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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The rest home has a large lounge, conservatory, dining area and recreational room with seating placed appropriately to allow for group and individual activities to occur. There are other smaller lounges available.

The dining room in the dementia unit is open plan with the kitchenette and nurses station in close proximity which allows observation of communal areas... There is a separate lounge in Rata Haven which allows for separate group or individual activities to occur. Residents interviewed (six rest home) are happy with their bedroom space.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

**Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are cleaning and laundry policies and processes. Internal and external cleaning audits occur. The laundry is located away from the resident areas and operates 5.5 hours per day laundering all linen and personal clothing. There is a dirty and clean laundry entrance and dirty/clean work areas in the laundry. Colour coded laundry bags are delivered to the laundry door. Sluice washing is done at the end of the day. The laundry is spacious with washing, drying, folding and storage of linen areas. Adequate linen supplies were sighted. Infectious laundry is delivered to the laundry door in sealed iso-bags that dissolve during the sluice wash. The laundry is well equipped with commercial washing machines, commercial dryers and a drying room. All equipment is checked six monthly. There is adequate ventilation in the laundry. Protective clothing is available including gloves, disposable aprons and face shield. There are designated locked cleaning cupboards. The cleaner works a seven hour day with duties including collecting rubbish, dusting, cleaning of all basins/ toilets/showers of all resident areas and staff areas and the sluice room. Spring cleaning of rooms are rotated. All cleaning equipment and mop heads are colour coded. The cleaner's trolley is well equipped and stored in a locked cupboard. Ecolab provide the chemicals, product use wall charts, conduct quality control checks and training as required. An Ecolab system is in place for cleaning chemicals. Cleaning and laundry staff observed are wearing appropriate protective wear. Interviews with six rest home residents state their personal clothing is laundered with care.</p>

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

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

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

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

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

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The service has emergency equipment and supplies that are accessible. Emergency training is included in the orientation.

Fire and evacuation notices are posted throughout the rest home. Residents are informed of fire evacuation process on admission and as appropriate. The service has an approved evacuation plan. Fire drills are conducted six monthly. PSC Coombræ has emergency lighting, gas barbeque, generator, bottled gas, water supply, blankets and bulk food for three days stored. The facility has a contingency plans for back up supplies. There is a nurse call bell system in place in resident's rooms, toilets, bathrooms and communal areas. Residents interviewed reported that call bells were answered promptly by staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

### **Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All bedrooms and communal rooms have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated appropriately and maintained at a comfortable temperature. Heat pumps provide heating and air conditioning. There is also radiator heating in the rest home area. Residents (six rest home) and relatives (four rest home and four dementia care) interviewed confirm the environment and the bedrooms are warm and comfortable

### **Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)**

Areas used by consumers and service providers are ventilated and heated appropriately.

**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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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

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

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### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0</p> <p>The service currently has a restraint free environment. There is a restraint approval group at an organisation level that reviews restraint across all services. E4.4a the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practices through the management of challenging behaviour.</p>

**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.

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

**Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>

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

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>

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

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

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Services use restraint safely

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

**Attainment and Risk:** Not Applicable

**Evidence:**

#### Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** Not Applicable

**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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** Not Applicable

**Evidence:**

### Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

**Attainment and Risk:** Not Applicable

**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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>

### Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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### Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a QPS benchmarking system in place. The scope of the infection control programme policy and infection control programme description are available. There is an established and implemented infection control programme that is linked into the risk management system.

The infection control coordinator is a senior registered nurse who works closely with the staff. The infection control committee includes a cross section of staff all areas of the service as part of the quality committee. The committee and the governing body is responsible for the development of the IC programme and its review.

Staff are well informed about infection control practices and reporting. They can contact the infection control coordinator if required and concerns can be written in progress notes and the communication book. For after hour's requirements, the clinical manager is available. Suspected infections are confirmed by laboratory tests and results are collated monthly. Each quarter statistics are sent to the Australian QPS benchmarking programme.

Summaries/graphs of these results are feedback to PSC Coombrae and compared with other PSC homes and homes of equivalent size in Australia. There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection. There is a risk factors for nosocomial infection policy, an accidental infectious exposure, TB, management of staff found positive for MRSA, guidelines for staff visiting overseas, risks and exposures for the pregnant healthcare worker, work restrictions for healthcare personnel exposed to or infected with infectious diseases, handling deceased residents with communicable diseases, guidelines for isolation, transferring of residents with an infection, isolation policy, and procedure for when an outbreak of infection occurs. There is evidence (signage) of preventative measures have been taken to prevent client exposure to infectious diseases such as Norovirus and influenza.

In August 2013 the facility had an outbreak of Gastroenteritis. Twelve residents and five staff members were affected. An Action plan for the management of the outbreak was sighted which included an infection log and documented preventative measures put in place to prevent the spread of infection. This included closing Rata Haven dementia unit to visitors, signage placed at the entry to the facility advising of the infection, an education update for staff on the use of PPE, the management of the roster to prevent overlap of staff working in both the dementia unit and rest home and dedicated members of staff appointed to care for those residents with symptoms. Communication with family regarding the outbreak is documented.

### **Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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

**Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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

**Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings. The infection control committee is made up of a cross section of staff from all areas of the service including; care giving, kitchen, cleaning and laundry and professional nurses. The facility also has access to the DHB infection control nurse, Public Health, Med Lab, G.P's and expertise within the organisation.
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

#### Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

**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 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

**Attainment and Risk:** FA

**Evidence:**

The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.

Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI's, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s)

disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases.

There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job descriptions, waste disposal, notification of diseases and educational hand-outs.

### **Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)**

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

**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 3.4: Education (HDS(IPC)S.2008:3.4)**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

There is an infection control coordinator is a registered nurse. The PSC infection control nurse peer support day in April 2013 included a variety of speakers, including Bug Control.

The infection control coordinator also has access to the microbiologist, pharmacist, and Med Lab for additional education for both the coordinator and the staff.

Staff were last provided with infection control education in June 2013. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza.

**Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)**

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

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

**Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)**

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service.

The service utilises an external benchmarking programme which analyses service data on a quarterly basis. The quality coordinator also conducts benchmarking against their own infection rates from previous years by identifying K.P.I's. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available.

All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

### **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.

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

### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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