

Presbyterian Support Central - Kowhainui Complex

Current Status: 11 February 2014

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

General overview

Kowhainui is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 79 residents. There were 33 rest home beds and 41 hospital beds occupied at the time of audit.

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

The previous shortfalls around staff orientation, clinical documentation and evening meals have all been addressed. This audit identifies improvements required around interventions, aspects of medicine management and food safety training.

Audit Summary as at 11 February 2014

Standards have been assessed and summarised below:

Key

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

Consumer Rights as at 11 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 11 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 11 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 11 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 11 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 11 February 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Presbyterian Support Central
Certificate name:	Presbyterian Support Central - Kowhainui Complex
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Kowhainui Complex
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 February 2014 End date: 12 February 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	74

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	8
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2.5

Sample Totals

Total audit hours on site	12	Total audit hours off site	10.5	Total audit hours	22.5
Number of residents interviewed	4	Number of staff interviewed	7	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	95	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	0

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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 18 March 2014

Executive Summary of Audit

General Overview

Kowhainui is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 79 residents. There were 33 rest home beds and 41 hospital beds occupied at the time of audit. There a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support. The previous shortfalls around staff orientation, clinical documentation and evening meals have all been addressed. This audit identifies improvements required around interventions, aspects of medicine management and food safety training.

Outcome 1.1: Consumer Rights

There is an open disclosure policy and an interpreter's policy in place. Staff have a good understanding of these policies, interpreter services are available if needed. Families and residents report the care manager and staff keep them informed of their family member's status and the management team are very approachable should they have any concerns. There is a complaints policy supporting practice and a complaints register. Resident and family interviews confirmed their understanding of the complaints process. There has been two complaints, these have been closed with no further action required, Health and disability advocacy had been offered.

Outcome 1.2: Organisational Management

The service is managed by a manager with significant aged care management experience who is supported by two care managers (rest home and hospital) who are registered nurses. The service employs a quality co-ordinator who is a registered nurse. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that is being implemented at Kowhainui. 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. There is a monthly quality council meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also staff meetings and resident 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 and staff 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. There is evidence of completed orientations in staff files sampled. This is an improvement from the previous audit.

Outcome 1.3: Continuum of Service Delivery

The registered nurse is responsible for each stage of service provision. Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The residents' needs, interventions, objectives/goals have been identified in the long-term support plans and these are reviewed at least three 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 documentation of interventions. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident focused and planned around everyday activities that meet the individual abilities, preferences and choice. Community links are maintained.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around aspects of medicine management. All meals and baking are prepared and cooked on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. There has been an improvement around the evening meals since the last audit. This audit identified a requirement for food safety education for seven staff employed in food services.

Outcome 1.4: Safe and Appropriate Environment

The building has a current building warrant of fitness and fire service evacuation approval.

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. There are currently 17 residents using enablers at Kowhainui, file review shows all enabler use is voluntary.

Outcome 3: Infection Prevention and Control

The infection control policies and procedures are documented. The infection control coordinator (RN) takes 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 coordinators with assistance from the quality coordinator and quality council through the monthly quality meeting. There is an online infection register in which all infections are documented and graphed monthly.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	2	1	0	0
Criteria	0	38	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	(i)One hospital resident reviewed by the psychiatrist for challenging behaviour does not have a behaviour assessment in place documenting alternative strategies/activities for the de-escalation of challenging behaviours as per the psychiatrist letter. ii) Two hospital residents with reports of a) wound pain and b) exacerbation of a chronic pain do not	(i)Ensure alternative strategies/activities for the de-escalation of challenging behaviours are documented in the care plan/behavioural assessment. ii) Ensure pain assessments are completed for all residents who identify with chronic, breakthrough or new pain episodes. Ensure there is monitoring of the effectiveness of pain	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>have pain assessments completed. One rest home resident on regular and prn analgesia for breakthrough pain does not have a pain assessment or monitoring of the effectiveness of pain. The initial assessment for one rest home resident does not identify a high pressure area risk as per the nursing discharge summary.</p> <p>iii) Two wounds have become chronic. They are written onto the wound short term care plan. The chornic wounds are not linked to the long term care plan.</p>	<p>relief. iii) Ensure chronic wounds are documented on the chronic/complex wound care plan and linked to the long term care plan.</p>	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and	PA Moderate	Three out of 12 medication signing sheets have "am" documented as the time given for non-packaged medications. One resident has an inhaler prescribed	Ensure the time is entered for administration of medications. Ensure the right doses are administered as prescribed on the medication chart.	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		medicine reconciliation in order to comply with legislation, protocols, and guidelines.		twice daily, which is being administered daily.		
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	There is no evidence for seven of nine staff employed in food services of food and safety training/refreshers in the last four years.	Ensure staff involved in the preparation and serving of food receive food safety and hygiene training.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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): <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

Attainment and Risk: FA
Evidence: <p>The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. Complaints information is included in the entry pack. The manager is the privacy officer for the facility. Care managers are involved in clinical concerns. Complaints are reported to the regional manager and involve human resource department for staff issues. Residents and family members interviewed state the management and staff are very approachable at any time to discuss their relatives health status or if they have any concerns. They feel listened to and concerns are addressed. There is a complaints folder and 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 the two complaints (October 2013 and January 2014) are included on the register with evidence of follow up and resolution. Advocacy was offered and involved in the most recent complaint.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The service has reviewed its 2013 quality and risk management plan against the goals and provided a progress report to head office. Planning is in place

for the 2014-2015 site specific quality plan. The quality council meet in March to finalize the quality plan. Quarterly progress reports continue throughout the year. The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred. Staff are encouraged to submit quality improvement forms. The suggestions are reviewed at quality council meetings. Staff receive a letter from the quality council acknowledging their commitment to ongoing continuous improvement. All quality initiatives and innovations are recorded in a register.

Recent improvements include (but not limited to);

a) a new exercise programme introduced by the physiotherapist based on the arthritis foundation DVD to improve balance, strengthen muscles and promote safe mobilisation for the residents. The physio is working with the recreational staff to be able to incorporate the exercise into the activity programme. The benefits of the programme for the residents and staff is to aim to reduce the overuse of wheelchairs and support residents to achieve their goals.

b) The "sugar club" is a staff initiative to provide privacy for residents requiring blood sugar levels and insulin administration at meal times. There is a portable screen that can be used in the dining/ lounge or other communal areas that provides privacy and timely recordings and insulin administration for residents. On the day of audit, the sugar club is observed in operation and is well accepted by the residents.

c) The company dietitian has reviewed the evening meals. Resident likes and dislikes are accommodated. There are two meal choices. The menu is printed onto the back of the activity plan that goes out to each resident however, menu changes are not known until the menu board is seen. There is a meal comment book in each dining room. The cook (interviewed) confirmed the meal comment books are checked daily and any concerns noted and followed up.

Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) that is part of the quality and benchmarking programme that is implemented at Kowhainui. The service receives quarterly performance progress reports and quartile ranking within the QMP peer group. Monthly reporting data including accidents/incidents/near misses, infection control surveillance data, medication errors, staff hours are entered into the online register that is accessible to the clinical director. Graphs, trends and areas for improvement are generated for distribution to the committee meetings. There is evidence of corrective actions taken with unwanted trends such as medication errors. An investigation identified the medication person is often interruption during the medication round. Protocols were reviewed and medication competencies repeated. The medication person no longer carries the portable phone during medication rounds. This has led to a reduction in medication errors.

Formal management meetings take place two monthly. There is a set agenda template that covers quality improvements, review of quality goals, infection control and health and safety reports and reports from the care managers, restraint co-ordinator, quality co-ordinator, hotel services team leader (laundry, cleaning and kitchen), Eden committee and recreational team. Other committee meetings include; quality council (six weekly), registered nurse (RN) meetings (monthly), infection control (six weekly), health care assistants (HCA), six weekly, Eden committee (monthly) and recreational (three monthly). The health and safety committee meets regularly. Representatives of each service and the unions are due for re-election March. The frequency of staff meetings is under review due to low attendance. Meeting minutes sighted. Staff receive six weekly newsletters containing information on organisational updates, committee reports, audits updates quality improvements, monthly reports, trends, corrective actions and general business. The frequency of meetings is currently under review and have not yet re-commenced for 2014.

The service has a quality coordinator responsible for coordinating the comprehensive internal audit schedule. Audits sighted cover clinical, medication, environmental, infection control, health and safety, food services, cleaning services, complaints and enablers. The quality co-ordinator ensures results are analysed, reported to relevant staff and head office, and corrective actions including re-audits are completed. Audits resulting in less than 85% compliance is re-audited with the aim of a 95% result. The internal audit schedule has been combined to include QMP and QPS monitoring (under review). Resident surveys (including food and activities), family/carer and staff surveys have been completed September 2013. Results ranged from 93 – 97%.

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 on-going progress around quality improvement. The service completes quarterly reports of the IC programme and the H&S programme to PSC quality coordinator. 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.

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

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 an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has been kept. The service benchmarking programme identifies keys 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 for the site 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 defence procedures are in place and supported by staff training attended June 2013.

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

D19.2g Falls prevention strategies such as falls risk assessments, moving and handling assessments, ultra-low beds, sensor mats and call bells within reach is evidenced in place.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <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.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. The service maintain a register of current practising certificates.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files reviewed included three health care assistants (HCA's), one enrolled nurse (EN), one registered nurse (RN) and one cleaner. Each staff file had a current employment contract, police vetting check, signed job description and completed orientation pack. Three staff are newly employed and not yet due for the three months appraisal. One staff member has completed a three months post-employment appraisal. Two staff have an annual appraisal. All staff sign a code of conduct on employment and sign an agreement to commence career force training.

A comprehensive orientation programme is in place in all six staff files sampled. This is an improvement from the previous audit. Four HCAs interviewed described the orientation process and felt supported. They completed a generic and work area orientation.

There is an implemented specific RN orientation book. RNs and enrolled nurses are linked into the professional development recognition programme at the DHB. They are also registered to attend the care study days at the DHB and InterRAI training has commenced.

There is a documented in-service programme for education. Competencies are identified and completed. The company is reviewing clinical manuals into a user friendly format with pictorials to aid learning. HCAs attend two full company study days per year that covers the compulsory training requirements. The ENs and HCA are completing the palliative care course.

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 caregivers.

Monthly reporting of training completed and percentages of staff attending is reported to the regional manager and clinical director monthly.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: 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. The manager is on call for facility matters and non-clinical concerns. The rest home and hospital care managers (CM) work 40 hours per week and they are on call for their areas. They are supported by RN cover over 24 hour periods. There is a RN on morning duty in the rest home and an enrolled nurse on duty in the afternoons. In the hospital area there is one RN on duty in the morning and one RN on a full afternoon shift and a second RN on a half afternoon shift. The night shift is covered by one RN and three HCA's across the facility. The HCA's working short shifts have hours "staggered" and are flexible to meet the acuity of residents as authorised by the care managers.

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

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <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 1.3.3: 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; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA
<p>Evidence:</p> <p>D.16.2, 3, 4: The six resident files sampled (three rest home and three hospital) identify the care manager (CM) or registered nurse (RN) completes 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. Five of six resident files sampled identified that the long term resident support plan is developed within three weeks. One resident has not been at the service three weeks. The resident/family/whanau sign the front page of the long term support plan to acknowledge their involvement in the development/review of the care plan. 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. Family contact stamps in the resident progress notes indicate discussions held with family regarding changes to health, care plan reviews, accidents/incidents, infections appointments, transfers to hospital and GP visits.</p> <p>16.5e: Six of six resident files sampled identified that the GP had seen the resident within two working days. It was noted in five of six resident files sampled that the GP had examined the resident three monthly and carried out a medication review. One resident is not due for a three monthly review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. The contracted GP visits the service twice weekly and at any other time for resident concerns. The GP also covers for the hospice and is readily available to visit palliative care residents in the hospital wing. The RNs are able to ring the emergency department for GP telephone advice or initiate a transfer to hospital. The GP was unavailable on the day of audit for interview.</p> <p>There is a 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. Progress notes are written daily. RN's report the HCAs are prompt to report any resident changes in health status. Communication diaries ad RN logs are maintained in the nurses stations in each area.</p>

The previous finding regarding the reporting of blood sugar levels in progress notes has been addressed.

Three hospital resident files sampled as follows; resident with frequent falls, resident with wound and resident with challenging behaviour.

Tracer methodology; hospital resident

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.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

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 four HCA's interviewed and two CM's stated that they have all the equipment referred to in support plans necessary to provide care, including 'five lifting hoists and two standing hoists (checked April 2013), pressure relieving mattresses and cushions, shower chairs, transfer belts, slidy sams, turntable, chair scales (calibrated August 2013) wheelchairs, gloves, aprons and masks. A health status summary held in the residents record records any significant events, investigations, GP visits and outcomes.

D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. All staff report that there are adequate continence 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 reports are in place for all wounds. A short term assessment and care plan is in place for four skin tears, two abrasions and one ankle ulcer in the hospital area. There are five skin tears and one abrasion in the rest home that are currently being treated. Two wounds have become chronic. Improvements are required around the documentation of chronic wounds. RNs and ENs attended wound management education in November 2013.

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. Continence management was included in the HCA study day in October 2013.

Behaviour management is described in the long term or short term support plan. Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The community psychiatrist for elder health will visit residents who are under the service. There is an improvement required around documentation of interventions for challenging behaviour. A range of assessment tools is completed on admission 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. There is an improvement required in regards to pain assessments.

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.

Attainment and Risk: PA Low

Evidence:

Behaviour management is described in the long term or short term support plan. Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The community psychiatrist for elder health will visit residents who are under the service. A range of assessment tools is completed on admission 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. Risk assessment tools are reviewed three monthly as part of the three monthly review. 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 reports are in place for all wounds.

Finding:

(i) One hospital resident reviewed by the psychiatrist for challenging behaviour does not have a behaviour assessment in place documenting alternative strategies/activities for the de-escalation of challenging behaviours as per the psychiatrist letter. ii) Two hospital residents with reports of a) wound pain and b) exacerbation of a chronic pain do not have pain assessments completed. One rest home resident on regular and prn analgesia for breakthrough pain does not have a pain assessment or monitoring of the effectiveness of pain. The initial assessment for one rest home resident does not identify a high pressure area risk as per the nursing discharge summary. iii) Two wounds have become chronic. They are written onto the wound short term care plan. The chronic wounds are not linked to the long term care plan.

Corrective Action:

(i) Ensure alternative strategies/activities for the de-escalation of challenging behaviours are documented in the care plan/behavioural assessment. ii) Ensure pain assessments are completed for all residents who identify with chronic, breakthrough or new pain episodes. Ensure there is monitoring of the effectiveness of pain relief. iii) Ensure chronic wounds are documented on the chronic/complex wound care plan and linked to the long term care plan.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The service employs a diversional therapy (DT) team leader who works full time and had 20 years' experience in the DT field. The DT team leader is an Eden associate/driver for the Eden philosophy. The organisation achieved accreditation of Eden principles three, four, five and seven in 2013 and are working towards achieving accreditation of principles six, eight and nine this year. The DT team leader leads a team of four (two DT's, one recreational officer and one DT assistant) to provide activities across the rest home, hospital, day-care and villas. There is a set programme across the facility that is resident focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, assisting the hairdresser, dusting, tidying drawers and making own beds (if able). A retired guide dog visits Monday to Friday.

The hospital programme is flexible according to the resident abilities and preferences. There is the ability to run activities simultaneously in both areas. There is a large lounge area in both units and a recreational room suitable for one on one or small group activities. Church services and other religious services for Easter, ANZAC and Christmas are held. Entertainment is provided on a regular basis and include musical groups, speakers, SPCA and pet visits, There is a wellness seminar held three monthly that is open to all residents and their families to attend. Guest speakers are invited to the seminars. Residents are encourage to maintain their community links with churches and external functions such as dances and the Scottish highland society for example. The residents enjoy interhome picnics, preschool visits, reading with school children and outings. There are designated drivers and the DTs have current first aid certificates. A resident advocate attends regular resident meetings. Lifestyle forms are completed in consultation with the resident and family on admission of a new resident. The DT completes a resident assessment within three weeks of admission and develops the activity plan within six weeks of admission. The clinical care plan and activity plan are reviewed at the same time.

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:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. The rest home and hospital areas have separate medication rooms. The supplying pharmacy delivers all pharmaceuticals, monthly regular and prn douglas medico packs. The returns are stored safely until collected. Two RNs check all medications on delivery and complete a medication audit form. Any discrepancies are fed back to the supplying pharmacy. All prn medications are checked monthly. The RNs, EN and senior health care assistants administering medications undergo an annual comprehensive medication competency, self learning package and attend annual education (May 2013). ENs complete an insulin administration competency to administer insulin in the rest home. Liverpool care pathway education was attended by registered staff February 2013. RNs attend syringe driver education at the hospice.

Controlled drugs in both medication rooms are stored safely in a locked safe and there are weekly stock checks. Liquid controlled drugs are measured. There is a six monthly pharmacy stocktake. The hospital maintains a stock of emergency medication including palliative care medications. There is a weekly check of stock and emergency equipment. The medication trolleys are kept in locked rooms. All eyedrops in use are dated. The medication fridge temperatures are monitored at least weekly. There is evidence of corrective action for temperatures outside of the accepted range. There are no standing orders. There are no self medicating residents.

Twelve resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted. There is a staff alert form used for changes in medication charts. Other lables used include "duplicate name". There are no gaps on the medication signing sheets. There are improvements required around some aspects of medication administration.

D16.5.e.i. 2, There is evidence of three monthly GP review of medications. PRN medications are prescribed correctly with indications for use.

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:

There is a staff alert form used for changes in medication charts. Other labels used include "duplicate name". There are no gaps on the medication signing sheets. Nine out of 12 medication signing sheets have the correct time of administration for non-packaged medications.

Finding:

Three out of 12 medication signing sheets have "am" documented as the time given for non-packaged medications. One resident has an inhaler prescribed twice daily, which is being administered daily.

Corrective Action:

Ensure the time is entered for administration of medications. Ensure the right doses are administered as prescribed on the medication chart.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

Attainment and Risk: PA Low
Evidence: <p>Food services policies and procedures manual is in place. The hotel services manager is responsible for the food services. There is a cook, cook assistant and kitchenhand on each day and an afternoon kitchen hand and tea lady (hospital area). 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. The cooks use an IT automatic ordering system that is linked to the recipes, menus and number of meals required. Recipes are available on line as well as “specials” week to celebrate special events. There is a vegetarian menu available and a number of ethnic recipes if required. Any changes to the menu is recorded and exceptions reported to the hotel services manager. Resident birthdays and special occasions are catered for. All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a folder of residents dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. There have been recent improvements to the evening meals with two options available. Residents and relatives interviewed confirm likes/dislikes are accommodated and alternative choices offered. There is a meal survey book available in the dining room that is monitored by the cook for feedback and suggestions on meals. This is an improvement from the previous audit. Toaster trolleys at breakfast are used to deliver hot toast to the rooms. Daily hot food temperatures are taken and recorded for each meal. A portable bain marie is used to deliver foods to the hospital dining room. Holding temperatures are taken. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled. The kitchen has a good work flow with a separate dishwashing area, preparation, cooking, baking and storage areas. The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitizer. Safety data sheets are available and training provided as required. Personal protective equipment is readily available and staff observed to be wearing hats, aprons and gloves.</p>

D19.2. The hotel services manager has almost completed a chef management course. The final unit covers assessment requirements. One kitchenahnd is current in food safety and hygiene training. There is no evidence for seven other staff employed in food services of food and safety training/refreshers in the last four years. This is an area requiring improvement.

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

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

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

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

Attainment and Risk: PA Low
Evidence: The hotel services manager has almost completed a chef management course. The final unit covers assessment requirements. One kitchenahnd is current in food safety and hygiene training.
Finding: There is no evidence for seven of nine staff employed in food services of food and safety training/refreshers in the last four years.
Corrective Action: Ensure staff involved in the preparation and serving of food receive food safety and hygiene training.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.2: 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:

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: The facility has a current building warrant of fitness that expires 22 June 2014.

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

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

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): <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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

<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. The service currently has a restraint-free environment. There are currently 17 residents using enablers (15 bedrails and two with thigh belts). There is an enabler register. Consent for enabler is signed and reviewed three monthly. Three resident files were sampled for residents with enablers. Consents are obtained from the resident/family/whanau and countersigned by the RN. There is an assessment form completed. Reviews are completed six monthly. The use of enablers are linked to the care plan. There is a 14 day monitoring period when enablers are commenced. Hourly monitoring of enablers in use is written in the progress notes. The restraints coordinator attends PSC peer support group and annual study days for restraints coordinators. The hospital care manager is the restraint coordinator. There is a restraint approval group at an organisation level that reviews restraint across all services. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures and a list of criteria for restraint that states one or more of the following conditions must be present in order for the restraint is to be implemented should this be required.</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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) 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, Med lab, public health and DHB that advise and provide feedback /information to the service. The infection control committee had attended training at the DHB. The service utilises the QPS benchmarking programme, which analyses service data on a quarterly basis. 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 council meeting. The meetings include the monthly infection control report and benchmarking 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. Graphs and data results are generated through the online intranet system and downloaded monthly for staff information. 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.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <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.

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