

CHT Healthcare Trust - Hillcrest Hospital

Current Status: 30 April 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

Hillcrest provides residential care for up to 80 residents at dementia, hospital and residential disability (physical) level care. There were 79 residents on the day of the audit. The facility is operated by CHT; the CHT group has strong board and effective governance practices. The current manager is new since the previous audit and has been in the role for three months. She is a registered nurse with significant experience managing aged care facilities. She is supported the area manager who is also a registered nurse. The clinical coordinator finished the day before the audit and the position is currently being advertised. Resident and family feedback during the audit was very positive, particularly around the positive change in culture since the new manager commenced. A well-developed staff education programme is implemented with compulsory external (ACE programme) enrolment for new staff training.

Four of the eight shortfalls identified in the previous audit have been addressed. These were around activities, hot water temperatures, first aid trained staff and restraint reviews. Some aspects of medication management have been addressed. There continues to be improvement required around care plan interventions, evaluations, aspects of medication management and restraint competencies for staff.

This audit has identified further areas for improvement around quality meetings, performance appraisals and aspects of staff training.

Audit Summary as at 30 April 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 30 April 2014

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

Organisational Management as at 30 April 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. | | Some standards applicable to this service partially attained and of low risk. |
|---|--|---|

Continuum of Service Delivery as at 30 April 2014

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

Safe and Appropriate Environment as at 30 April 2014

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

Restraint Minimisation and Safe Practice as at 30 April 2014

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

Infection Prevention and Control as at 30 April 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.0)

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: | CHT Healthcare Trust | | |
| Certificate name: | CHT Healthcare Trust - Hillcrest Hospital | | |
| Designated Auditing Agency: | Health and Disability Auditing New Zealand Limited | | |
| Types of audit: | Surveillance Audit | | |
| Premises audited: | Hillcrest Hospital | | |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); dementia level care; Residential disability services - Physical | | |
| Dates of audit: | Start date: 30 April 2014 | End date: 1 May 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: | | | 79 |

Audit Team

| | | | | | |
|--------------------------|-------|----------------------------|----|-----------------------------|---|
| Lead Auditor | XXXXX | Hours on site | 15 | Hours off site | 6 |
| Other Auditors | XXXXX | Total hours on site | 15 | Total hours off site | 6 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | XXXXX | | | Hours | 2 |

Sample Totals

| | | | | | |
|--|----|-----------------------------------|----|--------------------------------------|----|
| Total audit hours on site | 30 | Total audit hours off site | 14 | Total audit hours | 44 |
| Number of residents interviewed | 6 | Number of staff interviewed | 13 | Number of managers interviewed | 2 |
| Number of residents' records reviewed | 6 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 15 | Total number of staff (headcount) | 53 | Number of relatives interviewed | 5 |
| Number of residents' records reviewed using tracer methodology | 3 | | | Number of GPs interviewed | |

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 Thursday, 29 May 2014

Executive Summary of Audit

General Overview

Hillcrest provides residential care for up to 80 residents at dementia, hospital and residential disability (physical) level care. There were 79 residents on the day of the audit - 20 at dementia level care and 59 at hospital level care. There are five residents under 65 years old. The facility is operated by CHT, the CHT group has strong board and effective governance practices. The current manager is new since the previous audit and has been in the role for three months. She is a registered nurse with significant experience managing aged care facilities. She is supported the area manager who is also a registered nurse. The clinical coordinator finished the day before the audit and the position is currently being advertised. Resident and family feedback during the audit was very positive, particularly around the positive change in culture since the new manager commenced. A well-developed staff education programme is implemented with compulsory external (ACE programme) enrolment for new staff training.

Four of the eight shortfalls identified in the previous audit have been addressed. These were around activities, hot water temperatures, first aid trained staff and restraint reviews. Some aspects of medication management have been addressed. There continues to be improvement required around care plan interventions, evaluations, aspects of medication management and restraint competencies for staff.

This audit has identified further areas for improvement around quality meetings, performance appraisals and aspects of staff training.

Outcome 1.1: Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually, and as required. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints and all sighted complaints are well managed.

Outcome 1.2: Organisational Management

Hillcrest has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Aspects of quality information are reported to monthly combined staff and quality meetings. There is an improvement required around staff/quality meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at six weekly resident meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Hillcrest has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertaken external training. There is an improvement required around cultural safety and wound management training and performance appraisals. There continues to be improvement required around restraint competencies for staff. The service has a documented rationale for determining staffing and health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

Outcome 1.3: Continuum of Service Delivery

Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provides evidence that the provider has systems to assess the care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whanau input. Care plans are developed in V-care (computer programme) and demonstrate service integration. Care plans are rewritten six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Residents are assessed within set timeframes and receive well planned and co-ordinated services. There is an activities programme that operates over seven days, which offers a variety of activities suited to the needs of the residents. The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis. Medicines are managed via the blister pack system and policies reflect legislative requirements. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. Education and medicines competencies are completed by all staff responsible for administration of medicines. Staff that administer medicines have been assessed as competent. All food is cooked on site by the cook, all residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. This audit has identified improvements required by the service around of care plan documentation and evaluation and medication management.

Outcome 1.4: Safe and Appropriate Environment

The building is purpose built. Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. All bedrooms, bathrooms and communal areas have a call bell system. There is current building warrant of fitness. Hot water temperatures are monitored monthly and recordings show they are within safe limits.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently 10 residents requiring restraints and eight residents using enablers, the dementia unit is restraint free. Staff are trained in restraint minimisation and challenging behaviour management.

Outcome 3: Infection Prevention and Control

The infection control coordinator is a registered nurse. He is overseen by the facility manager who is also a registered nurse. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| Standards | 0 | 14 | 0 | 3 | 2 | 0 | 0 |
| Criteria | 0 | 39 | 0 | 3 | 2 | 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 | 31 |
| Criteria | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 57 |

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|------------|---|---|------------------|
| 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 | There have been no quality/health and safety or staff meetings from July 2013 until the new manager recommenced these in March 2014. There is some evidence that there may have been a meeting in October 2013 but no minutes can be located. | Ensure quality/health and safety meetings are held regularly so that all staff are informed of the results of quality improvement data. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--|---|-------------|---|--|------------------|
| | | employment practice and meet the requirements of legislation. | | | | |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | (i)Three of five staff files sampled do not have current performance appraisals. (ii) Two of the five files sampled for this audit did not have restraint validation questionnaires completed. (iii) There has been no training around wound management or cultural safety in the past two years. | (i)Ensure all staff have an annual performance appraisal. (ii) Ensure all staff have completed a restraint validation questionnaire. (iii) Ensure wound management and cultural safety training are completed regularly. | 180 |
| 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 Moderate | | | |
| 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 Moderate | i)Three out of six care plans reviewed identified that the care plans were not reflective of assessed needs of the residents or did not give clear direction instructions to guide staff in service delivery: 1) Resident A, no interventions for managing depression or challenging behaviour . 2) Resident B, no interventions for management of challenging behaviour, or wondering. 3) Resident C, no interventions for | i) Ensure all the resident assessed needs are reflected in the care plan. ii) Ensure that wounds are identified in the care plan/short term care plan. | 60 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--------------------------------------|---|-------------|---|--|------------------|
| | | | | the management of delirium and depression. ii) In 26 of 28 wounds including two of two pressure areas reviewed the care plan/short term care plan does not identify current wounds. | | |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | | | |
| HDS(C)S.2008 | Criterion 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. | PA Low | i) In four of six files reviewed the care plan evaluations are not documented at a level that indicates the progress towards meeting the desired outcomes. | i) Ensure that the care plan evaluations are documented and indicate degree of achievements or progress towards meeting the desired outcomes. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | i) Five out of 15 medication charts reviewed did not contain photo identification. ii) One RN was observed administering medication without checking the robotic sachet against the medication chart. | i) Ensure all medication charts contain photo identification. ii) Ensure all medications are checked against the medication chart before administration. | 30 |

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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Sixteen incidents/accidents forms were viewed for April 2014. The form includes a section to record family notification. All 16 forms indicated family were informed or if family did not wish to be informed. On interview six residents (from the hospital), five family members (two from the dementia unit and three from the hospital), seven health care assistants (who work across all areas) and three registered nurses all stated that family are informed following changes in the residents' health status.

The three registered nurses interviewed stated that they record contact with family/whanau. Contact records were documented in all files reviewed.

Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

A residents meeting occurs six weekly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. There is a policy that describes the availability of interpreter services when required.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

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.

D16.4b: Five family members interviewed stated that they are always informed when their family members health status changes.

D11.3: The information pack is available in large print and advised that this can be read to residents.

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:

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with six residents (from the hospital), inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints

There is a complaints register that includes all complaints. Complaints for 2014 were reviewed. Verbal and written complaints are documented. There have been seven complaints recorded on the register for this time period.

All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants in writing. Discussions with six residents and five family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with seven health care assistants (who work across all areas), stated that concerns/complaints were discussed at monthly staff /quality meetings.

D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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.

There have been two complaints to the DHB (from the same family) in November 2013 and January 2014. The first complaint related to a resident being assaulted by a health care assistant. Open disclosure was practiced and the family were informed of the first instance, but not the second. All 16 incident forms sample for this audit show that family were informed and the five family members (two from the dementia unit and three from the hospital), report they are always informed of incidents. The DHB investigation noted there was some missing documentation around the complaint. All complaints sighted for this audit have full documentation, investigation and written follow up with written and verbal complaints being documented and every complainant informed of how to contact the Health and Disability Commissioner if they are not satisfied with the outcome. The health care assistant concerned was dismissed following the investigation. The previous facility manager and the area manager met with the family and a letter has been sent to the complainants formally apologising for the physical abuse to the resident and advising of the internal review process and how to contact the Health and Disability Commissioner if they are unhappy with the outcome.

The second complaint related to management of the residents medication. On the day following admission the registered nurse identified that the doctors list of medications did not match the blister pack provided by the family. The doctor was contacted who confirmed the correct medications and the incorrect blister pack was sent to the pharmacy for destruction and a new blister pack provided (at the facilities cost). At discharge the family were given the remainder of the correct blister pack but are unhappy that the incorrect pack had been destroyed as they had paid for this. When the DHB representative reviewed the medications administered there were found to be administration errors. A review of 15 medication files for this audit found that this issue has been addressed.

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:

Hillcrest is a purpose built dementia and hospital facility. Hillcrest provides residential care for up to 80 residents at dementia, hospital and residential disability (physical) level care. There were 79 residents on the day of the audit - 20 at dementia level care and 59 at hospital level care. Five of these residents are under 65 years old and receiving residential disability level care. The facility is operated by CHT. The CHT group has strong board and effective governance practices. Hillcrest is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care.

Hillcrest has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan for 2014. The quality process being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. 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. Combined staff /quality / health and safety / restraint meetings discuss key components of the quality system and any issues are reported (link 1.2.3.6). There is a six monthly internal audit completed by the area manager and corrective action plans are used to manage shortfalls. The current manager is new since the previous audit and has been in the role for three months. She is a registered nurse with significant experience managing aged care facilities. She is supported the area manager who is also a registered nurse. The clinical coordinator finished the day before the audit and the position is currently being advertised. The manager and the clinical coordinator share on-call noting that currently this is all being covered by the manager. Job descriptions for the manager and the clinical coordinator outline their authority, accountability and responsibility. The manager has completed on-going training appropriate to their positions. There is RN cover in the facility 24/7.

ARC, D17.3di (rest home), D17.4b (hospital): The manager has maintained at least either hours annually of professional development activities related to managing a hospital and rest home.

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.

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: PA Low |
| Evidence: <p>Hillcrest has a quality framework that is documented. The manager is directly involved in operations at the facility and the clinical coordinator (RN) supports her in this role when the role is filled. There is a current business plan that includes goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (seven health care assistants (who work across all areas), three registered nurses and the manager); inform an understanding of the quality activities undertaken at Hillcrest.</p> <p>Resident meetings occur six weekly (minutes viewed). Six of six residents interviewed are aware meetings are held. Annual surveys are conducted of</p> |

residents and relatives. All residents and relatives interviewed stated they are asked for feedback regarding the service. The November 2013 survey was conducted by Press Gayney and compared Hillcrest to similar facilities in Australia and New Zealand. The benchmarked score against the standardised tool for all 298 facilities using the tool was 81.6. Hillcrest scored an average of 77.2 against this standardised tool. This indicates a drop of 5.1 points since the last survey. CHT has analysed these results and developed key messages to attend to the issues identified in the report and a schedule to carry out these improvements. The CEO is briefing all unit managers in the second day of the audit on the analysis and key issues identified. There are planned staff meetings following this briefing to ensure that the key improvement strategies are included in the reviewed Hillcrest business plan. The area manager also plans to hold open forums for further feedback and to assess improvement. It is noted that the survey was prior to the new manager and families and residents interviewed all reported improvements under the new manager.

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

D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

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 physiotherapy reviews and instruction around prevention in care plans.

Policies and procedures are in place with evidence of review. The manager and clinical coordinator manage quality systems. All staff are invited to attend the quality, health and safety meetings. There have been no quality meeting between September 2013, and when these were reintroduced by the new manager in March 2013. This is an area requiring improvement. It is noted that there is some reference to a quality meeting in October 2013 but no minutes for this possible meeting can be located. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff /quality meetings now these have been restarted. Meetings discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety.

Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Hillcrest has 10 residents requiring restraints and eight residents using enablers. The dementia unit is restraint free.

The area manager completes a comprehensive spot audit of the service six monthly. All issues found in the December 2013 audits have identified corrective action plans and resolutions. Several corrective action plans from this audit remain active and are being addressed by the new manager. Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is reported through to quality and staff meetings (when these occur). Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been completed and documented in the quality/staff meeting minutes. All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

Hillcrest has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be utilised. Seven health care assistants interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

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

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

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

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

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

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

| |
|---|
| Attainment and Risk: PA Low |
| Evidence: There is a facility wide spot audit that is conducted by the area manager. All issues found in the December 2013 audits have identified corrective action |

plans. Results of previous audits were discussed in quality and staff meetings.

Finding:

There have been no quality/health and safety or staff meetings from July 2013 until the new manager recommenced these in March 2014. There is some evidence that there may have been a meeting in October 2013 but no minutes can be located.

Corrective Action:

Ensure quality/health and safety meetings are held regularly so that all staff are informed of the results of quality improvement data.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

| |
|--|
| Corrective Action: |
| Timeframe (days): <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: There is a policy that describes accident/incident management. 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 reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the manager or clinical coordinator (when this position is filled) who monitor issues. All 16 incident forms sighted and have been signed by a registered nurse. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the quality, health |

and safety meetings (link 1.2.3.6).

Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Nineteen residents and five staff contracted a gastric bug (not confirmed as norovirus) in February 2014. The medical officer of health was informed of both in a timely manner.

Incidents/accidents for April 2014 were viewed and 16 forms were viewed from this time. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

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: PA Low

Evidence:

There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of RN's are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in two of five files reviewed. This is an area requiring improvement. It is noted that this short fall was identified in the internal 'spot audit' in December 2013 and a corrective action plan has been developed to address this.

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with seven caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. It is noted that there has been no training around wound management or cultural safety in the past two years. This is an area requiring improvement. Since the new manager commenced in February 2014 the service has introduced toolbox talks where there are short teaching sessions at handover relating to topical areas such as following an incident or infections. Interview with seven caregivers inform there is access to sufficient training and that this has improved under the new management. Medication competencies are completed for all RN's and the healthcare assistants who administer medication. These are checked by the clinical coordinator (noting that all were completed under the previous clinical coordinator).

The previous audit identified under criterion 2.2.4.1 that five of nine staff files sampled did not have a documented restraint competency. Two of the five files sampled for this audit did not have restraint validation questionnaires completed. The previous shortfall remains.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication.

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

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are 21 health care assistants that work in the dementia unit and all have completed the required dementia standards.

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: PA Low |
| Evidence: The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview with seven caregivers inform there is access to sufficient training. Medication competencies are completed for all RN's and health care assistants who administer medication. |
| Finding: (i) Three of five staff files sampled do not have current performance appraisals. (ii) Two of the five files sampled for this audit did not have restraint validation questionnaires completed. (iii) There has been no training around wound management or cultural safety in the past two years. |
| Corrective Action: (i) Ensure all staff have an annual performance appraisal. (ii) Ensure all staff have completed a restraint validation questionnaire. (iii) Ensure wound management and cultural safety training are completed regularly. |
| Timeframe (days): 180 (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:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the manager and the clinical coordinator will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. The manager is covering all on call while the clinical coordinator position is vacant. These standards are evident on review of the weekly rosters and discussions 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; 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

Evidence:

An admission checklist is completed. The organisation clearly identifies and communicates the level of detail within policies, to meet current accepted good practice and meet legislative requirements. Residents are assessed initially for a) risk of falls, b) risk of pressure areas, c) continence, d) pain (where appropriate), e) MNA depression scale. Reviews had occurred within the six month time frame in six of six files sampled but evaluations were not documented (link 1.3.8.2)

Fifteen of the 15 resident medicine records sampled show that the medicines have been reviewed three monthly.

Doctors' visits and allied health notes (physiotherapist, dietitian, podiatrist etc.) are included in resident files. Assessment/monitoring forms such as continence monitoring, risk of falls, risk of pressure areas and pain management are available also wound management and monitoring.

Seven health care assistants (who works across all areas) and three registered nurses interviewed could describe 'hand over' which occurs at the change of each shift.

The service has a variety of ways in which they ensure that the service is co-ordinated. Residents' progress notes are updated daily for hospital residents and at least weekly for dementia residents and these are readily available for all staff and allied health professionals to see. Staff meetings provide further opportunities for service co-ordination.

The GP was unavailable for interview on the day of audit.

Tracer Methodology residential disability.

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

Tracer methodology hospital:

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

Tracer methodology dementia:

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

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): <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.

| |
|--------------------------------|
| 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 1.3.6: 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 Moderate |
| <p>Evidence:</p> <p>Hillcrest provides services for residents requiring hospital and dementia level care. Residents' care plans are completed in V-care (computer programme) by the registered nurses in both areas. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation</p> <p>Six resident's care plans (three from the hospital and three from dementia), were reviewed for this audit. Six care plans evidenced six monthly care plan reviews. Three out of six care plans reviewed showed the care plans were not reflective of assessed needs of the residents or did not give clear direction instructions to guide staff in service delivery. The previous audit identified this shortfall which continues to require improvement. The care being provided is consistent with the needs of residents; this is evidenced by discussions with seven caregivers who work across the hospital and dementia areas, five family/whanau members, three RNs, the manager and the area manager. Residents' needs are assessed prior to admission and resident's primary care either changes to the GP who covers the service or they retain the services of their own doctor depending on their preference.</p> <p>There is evidence of referrals to specialist services such as podiatry, retinal screening, cardiology, wound care specialist nurse and the gerontology nurse specialist. There is also evidence of community contact.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-services and wound management in-service have been provided by external providers.</p> <p>Wound assessment and wound management plans and evaluations are in place for 28 wounds including two pressure areas. Twenty six of twenty eight wounds including two of two pressure areas did not have a wound identified in the care plan/short term care plan. This is an area that requires improvement. On interview the RNs and manager stated that they could access or make a referral to a wound or continence specialist nurse if they assessed that this was required. The GP assesses wounds regularly (documentation viewed).</p> |

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 Moderate |
| Evidence: Hillcrest provides services for residents requiring hospital and dementia level care. Residents' care plans are completed by the registered nurses in both areas. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The care being provided is consistent with the needs of residents; this is evidenced by discussions with seven health care assistants who work across the hospital and dementia areas, five family/whanau members, three RNs, the manager and the area manager. Residents' needs are assessed prior to admission and resident's primary care either changes to the GP who covers the service or they retain the services of their own doctor depending on their preference. There is evidence of referrals to specialist services such as podiatry, retinal screening, cardiology, wound care specialist nurse and the gerontology nurse specialist. Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. |
| Finding: i) Three out of six care plans reviewed identified that the care plans were not reflective of assessed needs of the residents or did not give clear direction instructions to guide staff in service delivery: 1) Resident A, no interventions for managing depression or challenging behaviour. 2) Resident B, no interventions for management of challenging behaviour, or wandering. 3) Resident C, no interventions for the management of delirium and depression. ii) In 26 of 28 wounds including two of two pressure areas reviewed the care plan/short term care plan does not identify current wounds. |
| Corrective Action: i) Ensure all the resident assessed needs are reflected in the care plan. ii) Ensure that wounds are identified in the care plan/short 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 diversional therapist employed by the service works at Hillcrest for two days a week. There are two activities coordinators who work a total of 60 hours Monday to Friday. The service is seeking to employ a weekend activities coordinator. Both activities coordinators speak a variety of Pacific languages which is a bonus as the facility has a large number of Pacific nation residents. On the day of audit, residents were observed being actively involved with a variety of activities in the lounges. In one lounge Pacific music was playing and residents reported they were enjoying themselves. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present |

interests, career and family. All recreation/activities assessments and reviews are up to date. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. The programme includes green prescription group exercises, Tai Chi, bingo, newspaper reading, word games and bus trips. There are also visits from community groups. Community groups such as the local school children, choirs, and community and church groups are part of the regular programme. The previous audit identified that community involvement be supported. This requirement has been met. All five family/whanau members interviewed stated that activities have improved, are appropriate and varied enough for the residents. All six residents interviewed stated they were happy with the activities available and are given a choice regarding attendance. D16.5d: Six of six 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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: PA Low |
| Evidence: |
| The care plan policy includes the evaluation requirements. Records of regular reviews with the GP have been maintained. D16.4a Care plans are reviewed six monthly or more frequently when clinically indicated in the form of a new assessment and new care plan. In four of six care plans reviewed the care plan evaluations are not documented at a level that indicates the progress towards meeting the desired outcomes. This is a previously identified shortfall that continues to require improvement. 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: PA Low |
| Evidence: The care plan policy includes the evaluation requirements. Records of regular reviews with the GP have been maintained. D16.4a Care plans are reviewed six monthly or more frequently when clinically indicated in the form of a new assessment and new care plan. |
| Finding: i) In four of six files reviewed the care plan evaluations are not documented at a level that indicates the progress towards meeting the desired outcomes. |
| Corrective Action: i) Ensure that the care plan evaluations are documented and indicate degree of achievements or progress towards meeting the desired outcomes. |
| Timeframe (days): 90 (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:

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. The day shift RN reconciles the medication on arrival from the pharmacy. This addresses a requirement from the previous audit ensuring safe medicine management system and ensuring medication is checked on arrival from the pharmacy.

The service has the robotic sachet system which is delivered every two weeks.

There are weekly checks of the controlled drug register. Medication errors are reported and managed through the incident reporting process. All opened eye drops are labelled.

A pharmacy contract is in place and the pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. This is an improvement from the previous audit.

All staff responsible for medicine management are competent to perform this function. All those deemed competent have completed documented medication competencies. Staff competencies are completed. There is a sample list of signatures and the registered nurse interviewed described their responsibilities in regard to medication administration.

The medications systems procedure includes a section "where residents are responsible for their own medication". This states a) "Store the medicines, including Controlled Drugs, in the resident's room in a locked cupboard or drawer that is accessible to the resident and staff and b) Medicines should be checked every week. Appropriate senior staff and the doctor must assess a resident's ability to take their own medicine at least every three months using SM172.Frm Self-Medication Checklist. Alerts are to be entered for all residents who are self-medicating. These alerts will be printed on the duty report.

The service currently has no residents self-medicating.

All documents and signing sheets are completed in ink and legible.

Five out of 15 resident medication charts reviewed had no photo identification. An improvement is required. Allergies//adverse reactions and duplicate names are noted. The signing sheets for PRN, oral medications and controlled drugs are correctly signed. On the day of audit one RN was observed administering medication without checking the robotic sachet against the medication chart. This is a previously identified shortfall that continues to require improvement.

D16.5.e.i.2; Medications are reviewed three monthly or as required by the G.P in 15 of 15 medication files reviewed. Medicines are only prescribed by GPs and paid for by the service when medicine is subsidised by Pharmac and includes packaging charges. The service encourages GPs to prescribe medicines that are funded.

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: A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. The service uses the robotic sachet medication system which is delivered every two weeks. The day shift RN checks the medication on arrival from the pharmacy. There are weekly checks of the controlled drug register. Medication errors are reported and managed through the incident reporting process. All opened eye drops are labelled. A pharmacy contract is in place and the pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. All staff responsible for medicine management are competent to perform this function. |
| Finding: i) Five out of 15 medication charts reviewed did not contain photo identification. ii) One RN was observed administering medication without checking the robotic sachet against the medication chart. |
| Corrective Action: i) Ensure all medication charts contain photo identification. ii) Ensure all medications are checked against the medication chart before administration. |
| 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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: FA

Evidence:

The CHT food service procedure provides information to staff about the food service procedure. Food services are contracted out and cooked on site by an external contractor. Policies on food service are developed and implemented. These policies and practices meet the requirements of the food hygiene regulations act 1974. There is a summer and winter menu approved by the Medirest dietitian. Four week menus for summer and winter are appropriate and varied. The contracted food services dietitian makes changes to the menu.

D19.2: Medirest employs an area manager (who oversees nutritional services), two cooks and three kitchen hands, all of which have completed the Medirest food safety programme.

A mini nutritional assessment is completed on admission for each resident and this is reviewed six monthly. Nutritional needs for each resident are entered on the care plan. Special diets are available and catered for as are resident preferences.

Dietary information forms are completed on admission and a copy given to the kitchen for their information. The dietary preferences of each resident are displayed on a whiteboard in the kitchen. The food service procedure states "Residents upon admission will have their individual preferences (likes/dislikes), religious and/or cultural requirements assessed by the care staff using SM190.Frm- Dietary Information. Form. This assessment may include input from the family/ whanau where appropriate.

There are copies of resident's food preferences/ dietary needs in the kitchen and the cook was able to identify which residents required special meals (such as diabetic) or those on REAP.

Meals supplied include as routine, breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times staff will provide a nutritious snack or drink if residents are hungry or thirsty. Extra snacks are provided when needed.

E.3f: There is evidence that there are additional snacks available over 24 hours.

Residents' weight is recorded on admission and monthly thereafter and was stable in three out of six resident files sampled. The other three: - one resident had been assessed by a dietitian, was on REAP level three and gradually gaining weight, the other two had been assessed and were overweight and their weight was to be continued to monitored monthly.

There is a comprehensive quality assurance programme implemented in the kitchen. The following is included monthly; a) food safety audit, b) food temperature monitoring, c) fridge, freezer and dishwasher temps daily, and d) incoming food temps. Medirest operates a 'balanced score card' monitoring process to ensure compliance with the quality processes. The kitchen is clean and well maintained.

The main grocery shop occurs weekly according to the menu. Food is stored in the pantry, the fridge and the freezer and temperatures are recorded daily. Food sighted in the fridge, freezer and pantry was covered and dated and raw food was stored below cooked food. Different coloured chopping boards are used for different food types and there is a roster for kitchen cleaning. The kitchen was clean on the day of the audit. The six residents (from the hospital) interviewed and five family (three from the hospital and two from the dementia unit) interviewed state they are happy with food temperatures and meals provided.

The service commenced using a Replenish Energy and Protein (REAP) programme in 2012. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and caregiver meetings. The documented programme has been developed by the Medirest dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. The service continues to evaluate and improve the REAP programme and initial results show a

marked decrease in weight loss for those using the programme.

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: 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 1.4: 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: <p>There is a current BWOFF that expires on 9 March 2015. The home is warm and well ventilated. All electrical equipment is checked and tagged bi annually this is current. This last occurred in October 2013. Staff report minor repairs and maintenance in a maintenance book kept at the nurses' station. Records indicate all maintenance and repairs are addressed in a timely manner. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. There is a maintenance manager who oversees the facility. The manager states that when an issue requiring maintenance is noticed the staff document this on the maintenance sheet. These are checked every day and in most cases the issue can be repaired or resolved on the same day. Otherwise the issue is assessed and an action plan developed on the same day. External contractors are engaged to complete work as required. Equipment is calibrated and serviced annually and this last occurred in September 2013. There is sufficient space so that residents are able to move around the facility freely. The hallways are wide enough with handrails appropriately placed.</p> |

All resident rooms are large enough to accommodate bed, chairs and lifting equipment. All rooms in all the hospital have en-suite shower and toilet. Flooring is appropriate, carpet in corridors and vinyl or carpet in rooms and vinyl in utility areas, and easily cleaned. .

The outside areas are easily accessed to decking with appropriate safety barriers.

Hallways throughout the facility allow residents to pass each other when using walking aids such as walkers or electric wheelchairs. There is non-slip lino in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted in the hospital and vinyl in the dementia wing. There are hand grips in bathroom and toilet areas. Residents were observed on the day of the audit, to independently and safely move around the inside and outside of the facility; other residents were observed to be assisted by staff. The six residents (from the hospital), interviewed and five family members (two from the dementia unit and three from the hospital), interviewed confirm the physical internal and external environment of the facility is appropriate to the residents' needs.

There is an outside area which is well maintained and safe. Residents were observed to be moving around in external areas with and without mobility frames and eight of eight residents interviewed reported that the outdoor areas are well enjoyed.

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, hoists, heel protectors and lifting aids.

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): <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> |

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:

The previous audit (in criterion 1.2.3.4) identified that hot water temperatures in resident's room fluctuate between 44 to 49 degrees Celsius. There was no action taken under 50 degrees Celsius. Hot water temperatures are recorded monthly and all temperatures for 2014 show that they are below 45 degrees Celsius. The previous issue has been addressed.

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

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

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

Attainment and Risk: FA

Evidence:

The previous audit identified that not all shifts have a staff member with a current first aid certificate on duty. All registered nurses now have first aid certificates (certificates sighted), there is always a staff member on duty with a first aid certificate. The previous issue has been addressed.

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): <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: There is a restraint policy There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of |

enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers. The restraint manual determines that enablers are voluntary and the least restrictive option. There are 10 residents requiring restraints and eight residents using enablers. The dementia unit is restraint free. Three enabler files were reviewed and included consents and assessments. E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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): <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 2.2.4: 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: FA |
| Evidence: The previous audit identified that two of five files sampled for residents who use restraint do not contain a documented restraint review. Ten files sighted for residents who use restraint evidence that at least six monthly restraint review occurs. The previous issue has been addressed. |

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: 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 8134.3:2008: 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: Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Hillcrest are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and carry out a monthly analysis of the data. The analysis is reported to the monthly staff/ quality meeting (link 1.2.3.6) and the monthly RN meeting. The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Internal audit of infection control is included in the six monthly spot audit. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting. |

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> |