# Radius Residential Care Limited - Radius Thornleigh Park

## Current Status: 19 May 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

Radius Thornleigh Park is part of the Radius Residential Care Group. Thornleigh Park provides care for up to 63 residents requiring hospital and rest home level care. On the day of the audit there were 43 residents receiving rest home level care and 19 receiving hospital level care. This audit has included assessing a further six rest home rooms in the facility as suitable to provide either hospital or rest home level care.

The facility manager has been in the role for two years. An experienced clinical manager who has been in the position for five months supports her. The regional manager (a registered nurse) also supports the facility manager. Families and residents spoke highly of the care provided at Thornleigh Park.

Three of the eight shortfalls identified at the previous audit have been addressed. These were around the complaints register, the hazard register, incident reporting, staff contracts and job descriptions, Improvements continue to be required around corrective action planning, staff orientations, performance appraisals, staff training, care planning and an aspect of medication documentation.

This audit has identified further improvements required around internal audits and infection control surveillance, neurological observations and wound documentation.

## Audit Summary as at 19 May 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 19 May 2014

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| 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 19 May 2014

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| 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 medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 19 May 2014

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| 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 19 May 2014

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| 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 19 May 2014

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| 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 19 May 2014

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

# 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

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| --- | --- |
| **Legal entity name:** | Radius Residential Care Limited |
| **Certificate name:** | Radius Residential Care Limited - Radius Thornleigh Park |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Radius Thornleigh Park | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 19 May 2014 | **End date:** | 19 May 2014 |

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| **Proposed changes to current services (if any):** |
| This audit has assessed six rooms that were previously used only for rest home level care as suitable to be used for either rest home or hospital level care. |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 62 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **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

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 14 | Total audit hours | 30 |

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| Number of residents interviewed | 12 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 40 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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| 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 Monday, 23 June 2014

## Executive Summary of Audit

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| **General Overview** |
| Radius Thornleigh Park is part of the Radius Residential Care Group. Thornleigh Park provides care for up to 63 residents requiring hospital and rest home level care. On the day of the audit there were 43 residents receiving rest home level care and 19 receiving hospital level care. This audit has included assessing a further six rest home rooms in the facility as suitable to provide either hospital or rest home level care.  The facility manager has been in the role for two years. An experienced clinical manager who has been in the position for five months supports her. The regional manager (a registered nurse) also supports the facility manager. Families and residents spoke highly of the care provided at Thornleigh Park. Three of the eight shortfalls identified at the previous audit have been addressed. These were around the complaints register, the hazard register, incident reporting, staff contracts and job descriptions, Improvements continue to be required around corrective action planning, staff orientations, performance appraisals, staff training, care planning and an aspect of medication documentation. This audit has identified further improvements required around internal audits and infection control surveillance, neurological observations and wound documentation. |

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| **Outcome 1.1: Consumer Rights** |
| There is an open disclosure policy and an interpreter's policy in place. Staff have a good understanding of these policies. Interpreter services are available if needed. Families of the resident’s report the manager and staff keep them informed of their family member’s status. Incident forms identify family is informed. There is a complaints policy supporting practice and a complaints register. Resident and family interviews confirmed their understanding of the complaints process. An up to date complaints register is maintained and all complaints show investigation and resolution. |

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| **Outcome 1.2: Organisational Management** |
| Radius has an organisational philosophy, which includes a vision, mission statement & objectives including a quality/risk management framework & process policy. The manager is suitably qualified in her role. The service's policies are reviewed two yearly, staff have access to manuals in hard copy and over the intranet. Policies are up to date.  Clinical guidelines are in place to assist care staff. The service collects internal data for monitoring purposes. Results are benchmarked against other Radius facilities. Staff are informed of internal audit results. There are improvements required around completion and storage of internal audits and corrective action planning. The service has a risk management programme. There is an organisational risk register in place and a site specific hazard register. All clinical events are being documented including pressure areas. Monthly aggregation of incident data (resident falls, skin tears, pressure areas, challenging behaviours and medication incidents) is undertaken and sent to Radius Head Office for benchmarking purposes.  Practising certificates are held in a central location for all registered, clinical staff. A recruitment, selection and appointment of staff policy are in place.  Thornleigh Park staff orientation programme is specific to the worker type and has been completed by all staff. A comprehensive training schedule is directed from the head office. There are improvements required around orientation documentation, staff training and performance appraisals.  An acuity and clinical staffing ratio policy is in place that includes a documented rationale for staffing the service. Staffing is designed to match the needs of the residents. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a well-developed assessment process and resident's needs are assessed prior to entry. There is an information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short term care plans are available for use. There are improvements required around aspects of care plan documentation and STCPs. Improvement is also required around handovers, neurological observations and wound management. Residents and relatives interviewed all spoke positively about the care and support provided by staff at Thornleigh. The activities programme involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.  The service medication management system follows recognised standards and guidelines for safe medicine management practice. Controlled medication balances are checked weekly. Staff complete competencies. There are improvements required around an aspect of medication documentation.  Meals are prepared on site. Food and fridge temperatures are recorded. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided. The activity programme and kitchen services have the capacity to cater for six extra hospital level care residents. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility building warrant of fitness was sighted and is current. Preventative and reactive maintenance occurs.  There was appropriate equipment sighted to facilitate safe care of hospital and rest home residents. The physical environment minimises risk of harm, the resident rooms are spacious, and homely. The building holds a current warrant of fitness. Electrical equipment is checked annually. Residents are able to bring their own possessions and are able to adorn their room as desired. This audit has assessed that a further six rooms in the facility that currently provide care for rest home level residents can be used to provide either hospital or rest home level care. All rooms are large enough for either hospital or rest home level residents. There are communal lounges, dining areas, and communal bathrooms that are able to cater for a further six residents at hospital level care. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has separate restraint and enabler registers for each unit that include the type of restraint/enabler, date commenced and comments. The registers are reviewed at the staff meetings. The facility is currently restraint free and there are four residents using enablers. |

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| **Outcome 3: Infection Prevention and Control** |
| There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the quality and risk management meetings and outcomes are reported to staff through nursing and staff meetings. Infection control surveillance is established that is appropriate to the size and type of services. There is an improvement required around including all infections in surveillance data. |

## Summary of Attainment

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 9 | 0 | 3 | 4 | 0 | 0 |
| **Criteria** | 0 | 31 | 0 | 5 | 5 | 0 | 0 |

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

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: 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 | (i)The internal audit schedule was not fully completed in 2013. (ii) Two internal audits for 2014 to date (medication and activities) cannot be located. It is noted that the facility health check provides evidence that these were completed. | (i)Ensure that all scheduled internal audits are completed. (ii) Ensure that completed internal audits are stored in a manner through which they can be retrieved for later reference. | 60 |
| HDS(C)S.2008 | Criterion 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. | PA Low | The three corrective action plans developed for service shortfalls identified in 2014 internal audits to date, do not have evidence of actions completed, resolution or sign off. | Ensure all corrective action plans document actions completed, resolution and sign off. | 60 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Two of five staff files sampled do not have documented orientation records. | Ensure all staff complete an orientation relating to their role and that this is recorded. | 90 |
| 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 Moderate | (i)The only staff training in 2014 to date was fire safety training in February as confirmed by registered nurse, health care assistant and manager interviews and recording in the in-service education folder. A number of required trainings have not occurred in the past two years including wound management, code of rights and restraint. Infection control training has not occurred in the past year. (ii) Trainings sessions that have occurred have had low attendance meaning not all staff are receiving required training. For example Treaty of Waitangi – five staff, challenging behaviour management – nine staff, abuse and neglect – eight staff. (iii) Four of five staff files sampled do not have a current performance appraisal noting that the other staff member is not yet due an appraisal. | (i)Ensure that sufficient training is provided to ensure staff have completed core trainings. (ii) Ensure that staff attendance at in-service education sessions is sufficient that all staff receive core trainings. (iii) Ensure all staff have an annual performance appraisal. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | i) One out of five long term care plans had not been completed within three weeks of admission. (ii) One of four care plans reviewed was not evaluated within the six monthly timeframes. | Ensure care plans are completed and evaluated within required timeframes. | 60 |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | Three of three health care assistants interviewed report they do not receive a handover at the beginning of their shift. | Ensure all staff receive a handover prior to commencing cares with residents. | 60 |
| 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) Two residents with unintentional weight loss did not have interventions documented in either a short term care plan or the LTCP updated. (ii) Food and fluid charts have not been completed as part of monitoring. (iii) Three residents who had experienced a fall with a knock to the head did not have neurological observations completed. (iv) Eight of nine wounds (including one pressure area) did not state timeframes for review. | i) Ensure interventions to manage a change in health status is documented on either a STCP or the LTCP is updated; (ii) Ensure food and fluid input is monitored where a risk is identified; (iii) Ensure neurological observations are completed for residents who have a knock to the head; (iv) Ensure all wounds have a review date. | 60 |
| 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 | Five out of ten medication charts did not have indications for prn use. | Ensure that prn medications include indications for use. | 60 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | (i) There are surfaces in the kitchen that have been damaged and can no longer be cleaned to the required standard; (ii) The kitchen cleaning schedule is not being followed and the kitchen has not been cleaned to the required standard. | (i) Ensure damaged surfaces are repaired; (ii) Ensure the kitchen cleaning schedule is followed and signed off. | 180 |
| HDS(IPC)S.2008 | Standard 3.5: Surveillance | Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 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. | PA Low | Infection control surveillance data does not include infections for which prescribed treatment such as antibiotics are not required. | Ensure all infections are included in infection control surveillance data. | 90 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## Outcome 1.1: Consumer Rights

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy. The communication with resident’s policy includes procedures to ensure that staff communicate well with residents and family members. There are monthly resident/relative meetings facilitated by the activities staff allowing residents/relatives to raise issues. Twelve residents (eight from the rest home and four from the hospital) stated they were welcomed on entry and were given time and explanation about services and procedures.   Nineteen incident reports were reviewed across the service. All recorded family notification. Five relatives interviewed (three from the rest home and two from the hospital) informed they are notified of any changes in their family member’s health status. The clinical manager, who investigates incidents, informed there are processes in place to support family notification of events.  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: All five relatives stated that they are informed when their family members health status changes.  The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.   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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints policy and procedure states that clients/family/whanau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and complaint forms or via suggestion box.   A client’s complaint procedure flow chart is included in the policy and is included in the information pack for residents on entry. Policy states that complaints process is to be visible and available in public areas.  Interviews with 12 residents (eight from the rest home and four from the hospital) and five relatives interviewed (three from the rest home and two from the hospital) were familiar with the complaints procedure and state all concerns /complaints are addressed.  The complaints log/register includes date of incident, complainant, summary of complaint, signature off as complete. All complaints sighted from June 2013 and 2014 to date (five complaints) are documented in the complaints register. This is an improvement since the previous audit. There have been six complaints in 2013. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints. This is an improvement since the previous audit.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. |

##### 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.

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

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

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

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

## Outcome 1.2: Organisational Management

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Radius Thornleigh Park is part of the Radius Residential Care Group. Thornleigh Park cares for residents up to 63 residents requiring hospital and rest home level care. On the day of the audit there were 43 residents receiving rest home level care and 19 receiving hospital level care.  The facility manager is an experienced in aged care and has been in the role for two years. An experienced clinical manager who has been in the position for five months supports her. The regional manager (a registered nurse) also supports the facility manager. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Thornleigh Park including strategic and operational issues, incidents and accidents, complaints, health and safety. Radius mission statement states that: "We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents" Radius has an organisational philosophy, which includes vision, mission statement & objectives including quality/risk management framework & process policy. Annual business quality/risk management plans are in place (sighted for 2014). A quality/risk management plan for 2014 has been developed for Radius Residential Care and Thornleigh Park has developed site specific objectives including:  1. Clinical and Operational key performance indicators 2. Clinical effectiveness 3. Consumer participation 4. Workforce effectiveness 5. Risk management 6. Taking ownership of the business and services provided 7. Effective financial leadership and management 8. Cost containment and reduction. The service has a documented structure that supports continuity of management and care delivery.  ARC, D17.3di (rest home), D17.4b (hospital), The organisation provides annual conferences for their managers and annual regional conferences and the facility manager attended a mini conference and a full conference in 2013. |

##### 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is an organisational quality/risk management plan - 2014 that includes clinical/care related risks, human resources; health and safety; environmental/service; financial; as well as site specific risks/goals identified for Thornleigh Park.  There are organisational policies to guide each facility to implement the quality management programme including (but not limited to); continuous quality improvement programme policy, continuous quality improvement methodology policy, quality indicator data collection policy and internal audit timetable. Staff have designated portfolios including incidents and accidents, training, restraint, health and safety and infection control. Interviews with three healthcare assistants and one registered nurse confirmed that infection control quality data is discussed at monthly staff meetings (staff and RN meeting minutes reviewed). The facility manager advised that she is responsible for providing oversight of the quality programme.  The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management. Assessment tools completed linked with resident care plans and were reviewed six monthly. There is an annual staff training programme that is based around policies and procedures (link 1.2.7.5). Internal audits are completed for care delivery compliance, care plans compliance, clinical records, medications, hand washing, privacy. However the internal audit schedule was not fully completed in 2013 and two internal audits for 2014 to date (medication and activities) cannot be located. It is noted that the facility health check provides evidence that these 2014 audits were completed. This is an area requiring improvement. D5.4 The service has the appropriate policies and procedures to support service delivery.  There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office . New policies/procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation (verified at interview with five healthcare assistants and two registered nurses). Staff have access to manuals (nurses stations and staff room). Policies are up to date and are located electronically on 'P' drive. Monthly reports by the facility manager to the regional manager are provided on service indicators. The quality meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, staff notice boards.   a) There are monthly accident/incident reports completed by the facility manager that break down the data collected across the service.  b) The service has linked the complaints process with its quality management system. Monthly manager reports to the regional manager include complaints. Staff meeting minutes identify discussion of complaints. c) There is an infection control data collection form which records all infections for which treatment is prescribed for each month (link 3.5.7). Infection control rates, outbreaks and results of internal audits are reported to the staff meeting and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.  d) Health and safety is an agenda item of the staff meeting. Any new hazards are discussed.  e) Advised that the restraint committee report through the staff meetings, feedback is provided to staff and RN meetings. Restraint use is also fed back to the organization through the clinical indicator reports. Restraint internal audits are completed yearly and results are also forwarded through monthly manager meetings. The facility is restraint free. Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. Quality improvement data such as hazards and infections are collected and analysed/evaluated and staff are informed through the registered nurses and staff meetings. Minutes of RN meetings verified audit results are discussed. Radius policy informs a corrective action plan is required where compliance is under a predetermined threshold. Corrective action plans were developed for incident reports (sighted) and all audits where there has been less than 95% conformity. The three corrective action plans developed for service shortfalls identified in 2014 internal audits to date do not have evidence of actions completed, resolution or sign off. This is a previously identified shortfall that continues to require improvement. 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 aggregating data monthly that includes considering time of occurrence There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff, monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency. There is an organisational risk register that includes identified risk and risk rating, identified action to prevent or minimize risk and persons responsible and covers areas such as clinical risk, human resources related risks, health and safety risks, environment/service related risks and financial risk. Each facility personalises to their site and this has occurred at Thornleigh Park. This is an improvement since the previous audit. Radius has a terms of reference for the health and safety committee defining membership to include healthcare assistants and a household representative. |

##### 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.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Monthly reports by the facility manager to the regional manager are provided on service indicators. The quality meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, staff notice boards.  a) There are monthly accident/incident reports completed by the facility manager that break down the data collected across the service.  b) The service has linked the complaints process with its quality management system. Monthly manager reports to the regional manager include complaints. Staff meeting minutes identify discussion of complaints. c) There is an infection control data collection form which records all infections for which treatment is prescribed for each month (link 3.5.7). Infection control rates, outbreaks and results of internal audits are reported to the staff meeting and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.  d) Health and safety is an agenda item of the staff meeting. Any new hazards are discussed.  e) Advised that the restraint committee report through the staff meetings, feedback is provided to staff and RN meetings. Restraint use is also fed back to the organization through the clinical indicator reports. Restraint internal audits are completed yearly and results are also forwarded through monthly manager meetings. The facility is restraint free. Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. Quality improvement data such as hazards and infections are collected and analysed/evaluated and staff are informed through the registered nurses and staff meetings. Minutes of RN meetings verified audit results are discussed. |
| **Finding:** |
| (i)The internal audit schedule was not fully completed in 2013. (ii) Two internal audits for 2014 to date (medication and activities) cannot be located. It is noted that the facility health check provides evidence that these were completed. |
| **Corrective Action:** |
| (i)Ensure that all scheduled internal audits are completed. (ii) Ensure that completed internal audits are stored in a manner through which they can be retrieved for later reference. |
| **Timeframe (days):** 60 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Corrective action plans are developed when service shortfalls are identified. |
| **Finding:** |
| The three corrective action plans developed for service shortfalls identified in 2014 internal audits to date, do not have evidence of actions completed, resolution or sign off. |
| **Corrective Action:** |
| Ensure all corrective action plans document actions completed, resolution and sign off. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| As part of risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure. There was evidence of indicator month by month data collection including (but not limited to): falls (no injury, soft tissue, fractures), skin tears, medication and pressure areas.   When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the registered nurse will undertake an initial assessment. The registered nurse will notify family and GP as required. The clinical manager collects incident reports daily and review both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse leader will investigate and escalate to the facility manager. Nineteen incident forms sampled evidence detailed investigations and corrective action plans following incidents excluding neuro observations for three residents who had a head injury (link 1.3.6.1).  Monthly data is taken to the staff meeting (link 1.2.3.6). The three healthcare assistants and one registered nurse interviewed could describe the process for management and reporting of incidents and accidents.  D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  D19.3c Discussions with the service (facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications.  Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Monthly aggregation of data is undertaken (falls monthly summary's sighted) and outcomes are discussed at all meetings - management, quality and staff meetings.   Nineteen incident forms were reviewed across the service and clinical actions were well documented (except neuro obs). Actions taken to minimise risk to individual residents are recorded. All incidents noted in the five resident files sampled had an incident form completed. This is an improvement since the previous audit. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Of the five staff files reviewed, two were registered staff - current practicing certificates were able to be reviewed. The facility manager reported a system is in place to check expiry dates. New registered staff are required to provide a practising certificate as part of the recruitment process. Practising certificates are sighted for: GP's, physiotherapist, pharmacy, podiatrist and dietician. Recruitment, selection and appointment of staff policy is in place. Five staff files were reviewed (one cook, the clinical manager, one registered nurse and two health care assistant). All have an employment contract and job description on file. This is an improvement since the previous audit. However two of five do not have orientation records on file and none of the five have a current performance appraisal (noting that one is not yet due). These are previously identified shortfalls that continue to require improvement. .  The organisation has a staff orientation policy. Thornleigh Park has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. The new staff member is then buddied for three shifts with an experienced healthcare assistant (HCA). The facility manager identifies suitably skilled HCA to be the 'buddy'. Interview of three healthcare assistants and one registered nurse informed there is an orientation process provided that included a period of being buddied.   The service has an internal training programme directed by head office. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. The previous audit identified that of the scheduled training sessions there are a number that have not occurred - eg. Cultural safety, abuse and neglect and emergency procedures noting these are annual requirements and from the information reviewed was not delivered during 2011. The only staff training in 2014 to date was fire safety training in February as confirmed by registered nurse, health care assistant and manager interviews and recording in the in-service education folder. A number of required trainings have not occurred in the past two years including wound management, code of rights and restraint. Infection control training has not occurred in the past year. (ii) Trainings sessions that have occurred have had low attendance meaning not all staff are receiving required training. For example Treaty of Waitangi – five staff, challenging behaviour management – nine staff, abuse and neglect – eight staff. Staff training is an area that continues to require improvement. D17.7d: Registered nurse competencies include: hand washing, manual handling, restraint, medication, syringe driver. A tracking process is in place to monitor requirements. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The organisation has a staff orientation policy. Thornleigh Park has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. The new staff member is then buddied for three shifts with an experienced healthcare assistant (HCA). The facility manager identifies suitably skilled HCA to be the 'buddy'. Interview of three healthcare assistants and one registered nurse informed there is an orientation process provided that included a period of being buddied. |
| **Finding:** |
| Two of five staff files sampled do not have documented orientation records. |
| **Corrective Action:** |
| Ensure all staff complete an orientation relating to their role and that this is recorded. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service has an internal training programme directed by head office. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. |
| **Finding:** |
| (i)The only staff training in 2014 to date was fire safety training in February as confirmed by registered nurse, health care assistant and manager interviews and recording in the in-service education folder. A number of required trainings have not occurred in the past two years including wound management, code of rights and restraint. Infection control training has not occurred in the past year. (ii) Trainings sessions that have occurred have had low attendance meaning not all staff are receiving required training. For example Treaty of Waitangi – five staff, challenging behaviour management – nine staff, abuse and neglect – eight staff. (iii) Four of five staff files sampled do not have a current performance appraisal noting that the other staff member is not yet due an appraisal. |
| **Corrective Action:** |
| (i)Ensure that sufficient training is provided to ensure staff have completed core trainings. (ii) Ensure that staff attendance at in-service education sessions is sufficient that all staff receive core trainings. (iii) Ensure all staff have an annual performance appraisal. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. The facility manager and clinical manager, both registered nurses work full time. The clinical manager is on call at all times except every second weekend where a senior registered nurse is on call. There is a registered nurse on duty 24 hours per day plus a second registered nurse on morning shift Monday to Friday and the clinical manager. The manager report s that if there is a change in the ratio of residents to more hospital residents extra caregiving staff will be employed. Staff turnover is low. The three healthcare assistants (who work across all areas) and one registered nurses interviewed stated that there is adequate staffing to manage their workload on any shift. The GP interviewed confirmed that staffing is appropriate to meet the needs of residents. Twelve residents (eight from the rest home and four from the hospital) and five relatives interviewed (three from the rest home and two from the hospital) interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly. |

##### 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.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures. A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.  Activity assessments and the activities sections care plans have been completed by the diversional therapist or the activities coordinator. A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) and nutritional assessment and g) pain assessment. Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. The registered nurses receive a handover from the registered nurse going off shift at the beginning of each shift. Three of three health care assistants interviewed report they do not receive a handover at the beginning of their shift. This is an area requiring improvement. All five files identified integration of allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. A GP interviewed spoke very positively about the service and describes effective communication processes. D16.2. 3.4: The five resident files reviewed (two from the rest home, three from the hospital) identified that in all five files a nursing assessment was completed within 24 hours and four of five files identify that the long term care plan was completed within three weeks. One out of five long term care plans had not been completed within three weeks. One of four long term care plans reviewed was not evaluated within the six monthly timeframes. These areas require improvement. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes.  Tracer Methodology Rest home:  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.* |

##### 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.

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.  D16.2. 3.4: The five resident files reviewed (two from the rest home, three from the hospital) identified that in all five files a nursing assessment was completed within 24 hours and four of five files identify that the long term care plan was completed within three weeks. Four out of five long term care plans had been completed within three weeks. Three of four care plans reviewed were evaluated within the six monthly time frames and one resident had been in the facility less than six months. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. |
| **Finding:** |
| i) One out of five long term care plans had not been completed within three weeks of admission. (ii) One of four care plans reviewed was not evaluated within the six monthly timeframes. |
| **Corrective Action:** |
| Ensure care plans are completed and evaluated within required timeframes. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Care plans are used by nursing staff and health care assistants to ensure care delivery is in line with the residents assessed needs. Activity assessments and the activities sections care plans have been completed by the diversional therapist or the activities coordinator. All five files identified integration of allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. A GP interviewed spoke very positively about the service and describes effective communication processes. The registered nurses receive a handover from the registered nurse going off shift at the beginning of each shift. |
| **Finding:** |
| Three of three health care assistants interviewed report they do not receive a handover at the beginning of their shift. |
| **Corrective Action:** |
| Ensure all staff receive a handover prior to commencing cares with residents. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service provides services for residents requiring rest home and hospital level. The prior audit identified a shortfall around care plans reflecting the current needs and interventions required. This has now been addressed. Five residents files (two from the rest home, three from the hospital), were reviewed for this audit. Three of five care plans did not evidence at least a six monthly care plan review (link 1.3.3.3). One was not due for review. Short term care plans are available for use. Short term care plans are not well used. Three residents with unintentional weight loss did not have short term care plans or food and fluid charts completed. The clinical nurse manager stated that short term care plans were commenced by the registered nurses but was unable to provide documented evidence. This is an improvement required from the previous audit that continues to require improvement. Three residents who had experienced a fall with a knock to the head did not have neurological observations completed. An improvement is required. Care being provided is consistent with the needs of residents; this is evidenced by discussions with three health care assistants who work both am and pm shifts and who work across rest home and hospital, five family/whanau members (three from the rest home, two from the hospital), one RN, the clinical nurse manager (RN) and the facility manager. A GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident’s primary care is provided by their own GP.  There is evidence of referrals to specialist services such as podiatry, hospice, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact. D18.3 and 4 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.  Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans are in place for six residents with wounds. Two residents have pressure areas. Eight of nine wounds (including one pressure area) did not state timeframes for review, therefore an improvement is required. On interview one RN and the clinical nurse leader stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There have been no wound specialist referrals required at this time. |

##### 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service provides services for residents requiring rest home and hospital level. Care plans are completed comprehensively. Short term care plans are available for use. Care being provided is consistent with the needs of residents; this is evidenced by discussions with three health care assistants who work both am and pm shifts and who work across rest home and hospital, five family/whanau members (three from the rest home, two from the hospital), one RN, the clinical nurse manager (RN) and the facility manager. A GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. |
| **Finding:** |
| i) Two residents with unintentional weight loss did not have interventions documented in either a short term care plan or the LTCP updated. (ii) Food and fluid charts have not been completed as part of monitoring. (iii) Three residents who had experienced a fall with a knock to the head did not have neurological observations completed. (iv) Eight of nine wounds (including one pressure area) did not state timeframes for review. |
| **Corrective Action:** |
| i) Ensure interventions to manage a change in health status is documented on either a STCP or the LTCP is updated; (ii) Ensure food and fluid input is monitored where a risk is identified; (iii) Ensure neurological observations are completed for residents who have a knock to the head; (iv) Ensure all wounds have a review date. |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a diversional therapist and activities coordinator employed for a total of 80 hours per week from Monday to Saturday. The activities coordinator is completing her ACE core papers and then will commence her diversional therapy training. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the activities lounge. 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. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing alongs, bingo movies and outings. There are also visits from community groups.  All five family/whanau members (three from the rest home, two from the hospital), interviewed stated that activities are appropriate and varied enough for the residents. All 12 residents (eight from the rest home, four from the hospital) interviewed stated they were happy with the activities available and are given a choice regarding attendance. D16.5d: Four resident files reviewed identified that the individual activity plan is reviewed when at care plan review. One resident file viewed had been in the facility less than six months.  The service is able to accommodate planned activity for six more hospital level residents. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a three monthly review by the GP. Overall changes in health status are documented and followed up, however link improvements identified 1.3.6.1. Care plan reviews are signed as completed by an RN. GP's review residents medication at least three monthly or when requested if issues arise or health status changes. D16.4a: Three out of five care plans was evaluated six monthly (link1.3.3.3). One was not due for review. D16.3c: Four out of five initial care plans were reviewed by a registered nurse within three weeks of admission (link1.3.3.3). |

##### 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.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident.  Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. All medications are administered by an RN. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All ten medication charts had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms.  There is a locked cupboard in a locked room that is used for controlled drugs. There is a drug trolley that is kept in the medication rom which is locked when not in use. Weekly checks of the controlled drug register are completed. Medication round observed; all practice is appropriate. A medication competency has been completed annually by all staff who administer medication.  There is a policy and process that describes self-administered medicines. There are currently no residents who self-administer medication. D16.5.e.i.2: Nine out of ten medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. One resident had been in the facility less than three months.  Medication charts now have no more than one copy. Copies are used when the GP faxes a medication change to the service. This is an improvement since the previous audit. Five of ten medication charts sampled did not have indications for prn use. An improvement is required. There are no gaps in the signing sheets, dosages given are recorded and there is no evidence of transcribing. The previously identified shortfalls have been addressed. |

##### 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are policies and processes that describe medication management that align with accepted guidelines. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident. Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. All medications are administered by an RN. There is a locked cupboard in a locked room that is used for controlled drugs. There is a drug trolley that is kept in the medication rom which is locked when not in use. Weekly checks of the controlled drug register are completed. |
| **Finding:** |
| Five out of ten medication charts did not have indications for prn use. |
| **Corrective Action:** |
| Ensure that prn medications include indications for use. |
| **Timeframe (days):** 60 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a workable kitchen. There are surfaces in the kitchen that have been damaged and can no longer be cleaned to the required standard. An improvement is required. The service employs two cooks and two kitchen hands to provide meal services over seven days a week. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. An RN completes each resident’s nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen. Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented. The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch. Food is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. All food is stored off the floor. There is a cleaning schedule. The kitchen cleaning schedule is not being followed and the kitchen has not been cleaned to the required standard. An improvement is required. Food bins and pantry shelves were dirty. Chemicals are locked away. Kitchen services are able to meet the demands for an increase in hospital level residents.  D19.2: Kitchen staff have been trained in safe food handling. |

##### 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.

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a workable kitchen. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch. Food is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. All food is stored off the floor. There is a cleaning schedule. Chemicals are locked away. |
| **Finding:** |
| (i) There are surfaces in the kitchen that have been damaged and can no longer be cleaned to the required standard; (ii) The kitchen cleaning schedule is not being followed and the kitchen has not been cleaned to the required standard. |
| **Corrective Action:** |
| (i) Ensure damaged surfaces are repaired; (ii) Ensure the kitchen cleaning schedule is followed and signed off. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The building holds a current warrant of fitness which expires in May 2015. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the facility manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person works 40 hours per week. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees. The facility's amenities, fixtures, equipment and furniture are appropriate for rest and hospital care residents. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. The home has a designated activity area which on the day of audit was well utilised. Resident’s bedrooms throughout the facility have resident's own personal belongings displayed. All bedrooms are large enough to accommodate rest home or hospital level residents. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.  D15.3d: 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, lifting aids. Interviews with three health care assistants confirmed there was adequate equipment. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint minimisation and safe practice policy & procedure includes; a) definitions, b) Use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance. Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form. The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.  There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed monthly.  There are four residents with enablers in the form of bedsides. These were requested by the residents as confirmed in the two files sampled for residents with enablers. The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of two files of the residents with an enabler. Thornleigh Park is a restraint free service. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme – infection control surveillance audit was last undertaken in September 2013 (100% compliance). The service submits data monthly to Radius head office where benchmarking is completed. There were no corrective action requirements from the audit programme. The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. However data does not include infections for which prescribed treatment such as antibiotics are not required. This is an area requiring improvement. This data is reported to the monthly staff meetings. Monthly data was seen in staff areas. |

##### 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.

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme – infection control surveillance audit was last undertaken in September 2013 (100% compliance). The service submits data monthly to Radius head office where benchmarking is completed. There were no corrective action requirements from the audit programme. The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. |
| **Finding:** |
| Infection control surveillance data does not include infections for which prescribed treatment such as antibiotics are not required. |
| **Corrective Action:** |
| Ensure all infections are included in infection control surveillance data. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |