

Presbyterian Support Central - Huntleigh

Current Status: 20 May 2014

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

General overview

Huntleigh rest home and hospital is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 71 residents. There were 26 rest home residents and 40 hospital level residents at the facility on the day of audit. There is a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

This audit identified improvements required around documentation of interventions, neurological observations and monitoring of facility food fridges. The service is commended for achieving a continuous improvement rating around activities and infection control surveillance.

Audit Summary as at 20 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 20 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 20 May 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 20 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 20 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 20 May 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 20 May 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		All standards applicable to this service fully attained with some standards exceeded.
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Audit Results as at 20 May 2014

Consumer Rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the main reception area of the facility. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents', cultural and spiritual preferences. Residents and family interviewed spoke very positively about care provided at Huntleigh Home. Complaints processes are implemented and complaints and concerns are managed within the required timeframes.

Organisational Management

The service is managed by a registered nurse manager with management experience who has been in the role six weeks. She has been completing orientation including company leadership and Eden training. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that has been implemented at Huntleigh Home. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. Quality committee and senior management meetings includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, two monthly resident meetings and relatives meetings three times per year. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

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

Continuum of Service Delivery

The service has a policy for admission and entry, a service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement are discussed with them. The registered nurse is responsible for each stage of service provision. Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The residents' needs, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. There is an improvement required around documentation for

wound management, pressure area interventions and neurological observations post head injury. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident focused and provides group and individual planned around everyday activities such as gardening, baking, crafts, outings and drives. There are strong community links including 20 volunteers and chaplaincy service. The service has been awarded a continual improvement (CI) rating for activities.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The company dietitian reviews the five weekly menus. Food services staff are aware of resident's likes/dislikes and alternative choices are offered. Vegetarian and ethnic dishes are available. There is an improvement required around the temperature monitoring of facility food fridges.

Safe and Appropriate Environment

Huntleigh rest home and hospital is a two level purpose built facility. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. Some rooms have an ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the residents. Residents can freely access communal areas using mobility aids. Each level has a kitchenette area, dining area, recreational room and lounge. Outdoor areas and the internal courtyard are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur, staff receive training in emergency procedures.

Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint is needed. There are currently 14 residents using bedrails and lap belts as enablers. Staff receive training around maintaining a restraint free environment. The enabler co-ordinator maintains enabler documentation and an online register.

Infection Prevention and Control

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator takes overall responsibility for ensuring that the surveillance programme is well implemented with review of trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information reviewed evidenced that trends are identified with corrective actions and outcomes communicated to staff.

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

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Presbyterian Support Central		
Certificate name:	Presbyterian Support Central - Huntleigh		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Certification Audit		
Premises audited:	Huntleigh Home		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 20 May 2014	End date:	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			

Audit Team

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

Sample Totals

Total audit hours on site	39	Total audit hours off site	16	Total audit hours	55
Number of residents interviewed		Number of staff interviewed		Number of managers interviewed	
Number of residents' records reviewed		Number of staff records reviewed		Total number of managers (headcount)	
Number of medication records reviewed		Total number of staff (headcount)		Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
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, 16 June 2014

Executive Summary of Audit

General Overview

Huntleigh rest home and hospital is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 71 residents. There were 26 rest home residents and 40 hospital level residents at the facility on the day of audit. There is a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support. This audit identified improvements required around documentation of interventions, neurological observations and monitoring of facility food fridges. The service is commended for achieving a continuous improvement rating around activities and infection control surveillance.

Outcome 1.1: Consumer Rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the main reception area of the facility. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents', cultural and spiritual preferences. Residents and family interviewed spoke very positively about care provided at Huntleigh Home. Complaints processes are implemented and complaints and concerns are managed within the required timeframes.

Outcome 1.2: Organisational Management

The service is managed by a registered nurse manager with management experience who has been in the role six weeks. She has been completing orientation including company leadership and Eden training. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that has been implemented at Huntleigh Home. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. Quality committee and senior management meetings includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, two monthly resident meetings and relatives meetings three times per year. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

Outcome 1.3: Continuum of Service Delivery

The service has a policy for admission and entry, a service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement are discussed with them. The registered nurse is responsible for each stage of service provision. Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The residents' needs, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. There is an improvement required around documentation for wound management, pressure area interventions and neurological observations post head injury. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident focused and provides group and individual planned around everyday activities such as gardening, baking, crafts, outings and drives. There are strong community links including 20 volunteers and chaplaincy service. The service has been awarded a continual improvement (CI) rating for activities.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The company dietitian reviews the five weekly menus. Food services staff are aware of resident's likes/dislikes and alternative choices are offered. Vegetarian and ethnic dishes are available. There is an improvement required around the temperature monitoring of facility food fridges.

Outcome 1.4: Safe and Appropriate Environment

Huntleigh rest home and hospital is a two level purpose built facility. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. Some rooms have an ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the residents. Residents can freely access communal areas using mobility aids. Each level has a kitchenette area, dining area, recreational room and lounge. Outdoor areas and the internal courtyard are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur, staff receive training in emergency procedures.

Outcome 2: Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint is needed. There are currently 14 residents using bedrails and lap belts as enablers. Staff receive training around maintaining a restraint free environment. The enabler co-ordinator maintains enabler documentation and an online register.

Outcome 3: Infection Prevention and Control

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator takes overall responsibility for ensuring that the surveillance programme is well implemented with review of trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information reviewed evidenced that trends are identified with corrective actions and outcomes communicated to staff.

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

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	2	41	0	1	1	0	0
Criteria	2	89	0	1	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA 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)The wound assessment for one sacral pressure area is incomplete (no date, signature or designation). Pressure area interventions are not documented on the short term or long term care plan. (ii) There is no wound assessment or management plan for a heel pressure area. The change of dressing for another sacral pressure area is not recorded as completed at the required frequency. (iii) One incident form in	(i)Ensure pressure area interventions are documented in the care plan. (ii) Ensure wound assessments and wound management plans are completed. Ensure treatments and/or change of dressings occur at the required frequency. (iii) Ensure neurological observations are completed following head injury.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				January 2013 did not show evidence that neurological observations were completed following a head injury.		
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	There are facility fridges used for the storage of residents foods. There is no evidence of temperature monitoring for the fridges.	Ensure all fridges used for the storage of resident foods are temperature monitored.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	CI	
HDS(C)S.2008	Criterion 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.	CI	Residents participate in everyday activities such as feeding, baking, outings for shopping and caring for the resident cats and budgies. The Eden alternative has been introduced into the home with staff actively participating and supporting new initiatives. HCAs are also actively involved in the theme days, festive occasions and one on one activities. Families are encouraged to attend activities, outings and entertainment with their relative. Eden "moments" are recorded in the resident progress notes. There are a number of volunteers involved in visiting and assisting with various activities. The volunteers continue to build a rapport with the residents. There are Duke of Edinburgh volunteers who spend individual time with residents playing scrabble, discussions, and

Code	Name	Description	Attainment	Finding
				<p>assists with cooking, gardening, reading and board games. One volunteer plays violin and piano in the weekends. Residents of Asian ethnicity have a volunteer who visits does Reiki massage for them. One volunteer who speaks fluent Russian regularly visits a Russian resident interpreting and conversing with the resident. The volunteer accompanies the resident to activities on the programme so that they may participate in the activities as desired. University students visit and have embraced the “adopt a resident” initiative. Residents particularly enjoy the interaction with young people including school and kindergarten children who write them letters.</p> <p>The chaplain (interviewed) visits the service twice weekly and more often as required for spiritual and non-spiritual support for the residents. He spends time with families and residents offering on-going support. There is a chaplain referral notebook and regular communication with the DT. The chaplain records visits in the resident notes. He has conducted resident funerals and blesses rooms within 24 hours. The chaplain also provides support to staff especially during palliative cares, dying and death of residents.</p>
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.	CI	
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.	CI	<p>Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. In early 2013 the service recognised that UTI numbers had increased and were above the benchmark compared to other facilities. An investigation showed some residents were not drinking sufficient fluids. Water was routinely provided to each resident on the table at lunch time. However healthcare assistants observed that even with encouragement residents frequently did not drink this. Residents indicated they would be more likely to drink juice so juice is now provided to all residents on the lunch table and staff report most residents drink this without prompting and those who don't are happy to drink it when prompted. To further increase fluid intake the service introduced providing ice blocks to residents on hot days. Following these initiatives the September QPS benchmarking data showed a reduction of UTI's by 60% at the facility. The care manager (the infection control coordinator) reports she has continued to monitor UTI rates closely and in August 2013 noted a slight rise. She then provided education to all residents about hand hygiene</p>

Code	Name	Description	Attainment	Finding
				including washing hands with soap and water and using alcohol gel that is located around the facility, at the September 2013 residents meeting. Following this UTI rates have dropped again in October and November 2013.

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Policies and procedures that adhere with the requirements of the Code are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. The Code was evident around the service. Staff receive training about rights at induction and through on-going in-service training. Interviews with three RNs (two RNs and one RN Infection Control coordinator) and seven healthcare assistants (two rest home/hospital and five hospital), showed an understanding of the key principles of the code of rights. Resident rights training was provided in 2012, 2013 and in April 2014 as part of the staff training workshop days scheduled two monthly in 2014.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

There is a welcome information booklet/folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family/whanau and, as appropriate, their legal representative. On entry to the service the manager or care manager discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy. On-going opportunities occur via regular contact with family/whanau. Advocacy pamphlets and the code of rights are located in the main reception area along with falls prevention and complaints pamphlets. Advocacy is brought to the attention of residents and families at admission and via resident two monthly and relatives meetings and the information pack. Interpreter services are available and information is clearly displayed.

Interviews with five residents (one rest home and four hospital), and four family/whanau members (two rest home and two hospital) all confirmed that that they were well informed and that information has been provided around advocacy.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, advocacy, interpreter services and H&D Commission information. Admission agreements signed by the residents and/or family also provide information. The code of rights poster is available on the walls around the service. English and Maori leaflets are available and large print leaflets are available when required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. Values and beliefs information and resident preferences are gathered on admission with family/whanau involvement and are integrated into the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with all seven healthcare assistants identified how they get to know resident values, beliefs and cultural differences. Interviews with five residents (one rest home and four hospital), confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with seven healthcare assistants described providing choice including what to wear, food choices, how often they want to shower, what activities were on for the day and whether they wanted to be participate in activities. Discussions with residents and family members confirmed that residents are able to engage in activities and access community resources as they choose</p> <p>Discussions with five of five residents (one rest home and four hospital) and four of four family/whanau members (two rest home and two hospital) were overall positive about the care provided. Resident and relative survey in September 2013 evidenced positive feedback regarding privacy dignity and respect</p> <p>During the visit, staff demonstrated gaining permission prior to entering resident rooms. Three RNs (two RNs and one RN Infection Control coordinator) and seven healthcare assistants (two rest home/hospital and five hospital) interviewed described ensuring privacy by knocking before entering private areas. This was observed during audit.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>D4.1a : Four of four families/whanau state that their family member were welcomed to the service and personal items and pictures were put up to assist them to settle into their new environment The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. The support plan includes a 'spirituality, faith and culture' section and this is completed in nine of nine resident files (four rest home and five</p>

hospital) sampled.

There is a sexuality and intimacy policy. The service includes within its care planning assessment, directions for emotional wellbeing and this includes sexuality and intimacy. This was evidenced in two of the resident's files that were married, allowing them privacy.

The service is implementing the Eden Philosophy and staff could describe a more resident-focused care instead of task orientated. There is an elder abuse and neglect policy. Elder abuse and neglect training is compulsory to attend at least every two years as part of the healthcare assistant (HCA) and registered nurse (RN) study days. Elder abuse and neglect training was completed in November 2013 and 28 staff attended.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). The Presbyterian Support wide Maori Health plan has been reviewed and updated through the Maori Health plan Wellington Group. There is a site specific Maori health plan. The Treaty of Waitangi is displayed in the main reception area.

Cultural and spiritual practice is supported. There are employee guidelines to guide staff in the delivery of culturally acceptable care for Maori residents. The service has access to a cultural advisor with links to two local Iwi, Takapu Whia Marae and Pipitea Marae from the Ngati Toa region. The service identifies the need for staff to be trained in delivering appropriately cultural services. Cultural/treaty training has been provided as part of the healthcare assistant and registered nurse (RN) study days for all staff. Cultural/treaty training was completed in 2013 and 2104. A total of 25 staff attended. There are currently no Maori residents. Discussions with staff identify that have responded appropriately to the cultural needs of residents and their whanau. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety when caring for Maori residents

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a spirituality, religion, faith and culture section in the care plan.</p> <p>D3.1g: The service provides a culturally appropriate service by identifying individual needs. There is one XXXXXX resident who speaks little English and has specific cultural needs identified in the care plan, including staff and family that act as interpreters (the residents husband is also a resident), likes to watch XXXXX TV, likes own culture but willing to fit in with Kiwi culture. Family bring in food treats, and the seven healthcare assistants and the cook (interviewed) are able to describe the resident's individual cultural needs.</p> <p>D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p> <p>The service provides a chaplaincy service eight hours per week which includes on-site church services and advocacy for residents, families and staff. Discussions with residents and family members confirmed they were satisfied that staff considered their individual values and belief. This was also reflected in support plans.</p>

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

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

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

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

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: There is a code of ethics policy. Job descriptions include responsibilities of the position and ethics, advocacy & legal issues. Registered nurse job descriptions include upholding legal and ethical standards and accountability and responsibility. The orientation booklet provided to staff on induction includes but is not limited to; a section on professionalism and standards of conduct, harassment prevention policy and gifts, understanding the code of conduct, privacy and confidentiality, spiritual needs, cultural responsiveness, sexuality and intimacy and information technology (IT) usage policy is signed as part of orientation. Completed orientation packages were sighted in nine of nine files sampled. Two RNs, one RN IC coordinator, one care manager and seven healthcare assistants interviewed have a good understanding of professional boundaries between staff residents and their families.

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

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

Attainment and Risk: FA
Evidence:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA
<p>Evidence:</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement. Policies and procedures cross-reference other policies and appropriate standards. Care planning is holistic and integrated and includes a three monthly review and a six monthly multi-disciplinary review meeting.</p> <p>RN's are encouraged and supported to continue education. Healthcare assistants are supported to complete Career Force or unit standards. The manager, care managers and quality coordinator attend training sessions appropriate for their positions. The manager is new to the service and was employed six weeks ago.</p> <p>A2.2 Services are provided at Huntleigh Home that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring.</p> <p>D1.3 All approved service standards are adhered to.</p> <p>D17.7c. There are implemented competencies for healthcare assistants and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>The service has implemented a number of improvements since the previous audit as a result of feedback from residents and relative satisfaction surveys in September 2013. These include: contracting a GP for twice weekly visits improving communication, employing a second care manager, consolidation of the Career Force training for support staff, trialling cultural dishes to improve food satisfaction, implementing the Eden philosophy and undertaking a pain project to improvement management of resident's pain.</p> <p>Resident meetings are held two monthly and relatives meetings are held three times a year</p> <p>Staff attend compulsory education and study days. Staff are required to read information/reviewed policies and procedures in the reading folder in the staff room and sign to acknowledge they had read them. Shift handovers ensures there is continuity of service delivery. Seven healthcare assistants interviewed are knowledgeable in the use of care plans and short term care plans which guide them in the safe and timely delivery of services for the resident.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Discussions with five residents and four family members all stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur two monthly and the facility manager and has an open-door policy. Ten accident/incident forms were sampled, five from May 2014 and four from January – March 2014 and one from September 2013 - all identified that relatives were informed in all cases.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. 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.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b. Four relatives (two hospital and two rest home) stated that they are always informed when their family members health status changes.</p> <p>D 13.3 Nine resident admission agreements sighted are signed. The admission agreement contains a schedule of fees and charges where applicable. Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</p> <p>The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs and pamphlets available at the main reception area. There is currently one resident who speaks little English and identified needs are evident in the care plan interventions including communication.</p>

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

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

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

Attainment and Risk: FA
Evidence: Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes the following: collection and storage of information, delivering of care including minor procedures as wound care, X-rays and podiatrist, photograph for display and identification purposes, transport and outings, family involvement in assessment, care planning and

evaluation of care and students delivering care. The consent forms also state the resident may withhold or decline to consent for any specific procedure. The care manager, two RNs, one RN infection control (IC) coordinator and seven health care assistants (HCA)s interviewed were knowledgeable in the informed consent process. All resident files have a resuscitation form. The GP signs to deem the resident competent or not competent. Where the resident is deemed incompetent the GP discusses medical indications for or not for resuscitation with the enduring power of attorney (EPOA) or family. The GP and RN sign the resuscitation form. Nine resident files sampled (five hospital and four rest home) had appropriately signed resuscitation forms.

D13.1: There were nine admission agreements sighted signed appropriately.

D3.1.d Discussion with four families (two hospital and two rest home) identified that the service actively involves them in decisions that affect their relative's lives. Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with seven healthcare assistants (two rest home/hospital and five hospital), four registered nurses (one care manager, two RNs and one RN IC coordinator) and the manager identify that consents are sought in the delivery of personal cares and this is confirmed by five residents interviewed (one rest home, four hospital). Resuscitation policy is implemented and there are signed forms in all resident files reviewed. Resuscitation forms are reviewed annually.

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

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

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

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

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Advocacy information is part of the service entry package and is on display on noticeboards around the facility and pamphlets available at the main reception area. The information identifies who the resident can contact to access advocacy services. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file. Staff (interviewed) are aware of the resident's right for advocacy and how to access and provide advocate information to residents if needed. The welcome booklet includes a section around 'client advocates'. One complaint evidenced on the complaints register that was resolved included an advocate from the health and disability services. The service provides a chaplaincy service eight hours per week which includes on-site church services and advocacy for residents, families and staff

D4.1d: Discussion with four family members (two rest home and two hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: The resident file includes information on resident's family/whanau and chosen social networks.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Family members and residents confirm that visiting can occur at any reasonable time. This is stated in the resident information pack. D3.1h Discussion with five residents shows that they are encouraged to be involved with the service and in their care. Residents can access community services as they require. Discussions with staff, residents and relatives identified that the service encourages residents to belong to community groups. As part of the Eden philosophy there is interaction with a local preschool, a primary school and a college. Students have built up relationships with particular residents. There are a large number of community volunteers, and community groups come and entertain. There is also interaction with the SPCA. D3.1.e Discussion with RNs, HCAs the activities officer, manager and the care manager indicates that residents are supported and encouraged to remain involved in the community and external groups visit.</p>

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A complaints process is in place. The complaints procedure is provided to residents and relatives at entry both in writing and verbally (evidenced in interviews with the manager, care manager, registered nurses and healthcare assistants). Residents and family members confirmed that management are very approachable should they have any concerns. Complaints information is included in the resident and relative information pack. The complaints form is readily available and attached to Enliven complaints brochure. The brochures are displayed in the main reception area.

There is a complaints folder and online register that includes complaints written and includes sign-off. There were no documented verbal complaints. The manager confirmed that she would document verbal complaints should they occur. All formal complaints are included on the complaints register and the PSC templates are used. The complaints folder and register has been kept up to date and all complaints are included on the online register with evidence of follow up and resolution. There has been one written relative complaint in May 2014. The complaint has been appropriately investigated and resolved to the satisfaction of the complainant. There were four written complaints in 2013. All complaints were appropriately investigated and resolved to the satisfaction of the complainant.

Discussions with five residents (one rest home and four hospital) and four families/whanau (two rest home and two hospital) confirm they are provided with information on complaints and understand the complaints process.

D13.3h: A complaints procedure is provided to residents with 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.

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Huntleigh Home is part of the Presbyterian Support Central (PSC) organisation. The service provides rest home and hospital level care for up to 71 residents. All the rooms can safely accommodate rest home or hospital residents. On the day of the audit there were 66 residents (25 permanent and one respite rest home residents and 40 hospital residents, one of which is under 65 years of age).

Huntleigh Home has a documented philosophy, mission, vision, values, goals corporate commitment and older person's services goals. The philosophy recognises positive ageing and things that are important to a healthy and happy life at any age. Huntleigh home is working towards the Eden Alternative and implementing the ten principles.

There is a company operational plan and site risk management plan evidences regular reviews for 2013. There is an Enliven (Huntleigh Home) business plan for 2013 – 2014 that is in progress with an action plan to meet the identified goals including corporate commitment and Enliven services goals.

The PSC building committee maintain close liaison and consult with the service regarding any plans for refurbishment or building development.

The manager (RN) is supported by a regional manager (non-clinical), a quality coordinator and two care managers (rest home/hospital first floor and hospital ground floor). The service has a robust central structure that supports the continuity of management and quality of care and support (including staff management). The management team (interviewed) feel well supported by the company. The manager was appointed to the role six weeks ago. She is a registered nurse with previous clinical and management experience. She has completed a post graduate diploma in district nursing and respiratory nursing and is currently completing a master's degree in clinical nursing management and research. The manager has a background of 10 years as a ward manager medical ward and manager of an aged care facility for 10 years in the UK. She has attended training on the Eden Alternative. The manager is supported by the regional manager. The regional manager has been in the position for five years and supports seven PSC facilities in the lower North Island. The regional manager reports to the general manager of the governing body, Enliven. The regional manager meets with the managers 1-2 weekly and holds a monthly managers meeting. All PSC managers meet 3-4 times a year. The central Enliven office employs a clinical director, two nurse consultants and a quality coordinator that are responsible for the professional training and development and review of policies and procedures.

The manager is also supported by two RN/care managers one of whom has been Huntleigh Home PSC over 10 years. Enliven also provides a two day education seminar annually for all care managers to ensure that they receive at least eight hours annual professional development activities related to overseeing clinical care.

ARC D17.4b The manager has maintained at least eight hours annually of professional development.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the absence of the manager an individual with relevant experience is delegated with the responsibility of fulfilling the manager role. The delegated persons are the two care managers with support from the regional manager.

D19.1a; A review of the documentation, policies and procedures and discussion with staff identified that the service has operational management strategies and a quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator on-site for two days per week. The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to continually improve the service delivery to its residents.</p> <p>PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS quarterly benchmarking programme that is implemented at Huntleigh Home. Benchmarking includes but is not limited to; pressure injuries, complaints, skin tears, falls, accidents, wound infections, infections, staff turnover and care staff work hours. The service has a quality coordinator that has been employed at the service for five and a half years. She has a background in quality management and management of a rest home. Quality meetings include key staff from all areas of service. Quality reports provided to the committee by members include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry/ domestic/cleaning monthly report, e) IC monthly report, f) enabler monthly report, g) clinical monthly report, h) managers monthly report, i) activities monthly report, j) education monthly report, k) maintenance report (meeting minutes signed).</p> <p>Other regular site meetings include; professional nurses meetings, care meetings, enabler co-ordinator meetings, health and safety meetings two monthly, recreational staff meetings, kitchen meetings, resident meetings two monthly and relatives meetings three times a year. There is also an Eden associate meeting three monthly. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the</p>

organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement.

The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator.

The internal audit company schedule has been combined to include QMP and QPS monitoring. The service completes the mandatory audits and chooses an additional audit monthly. Reports completed identify criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. When a shortfall is identified the area is re audited until a satisfactory result is obtained. The quality co-ordinator (interviewed) is responsible for ensuring corrective actions have been implemented and signing off audit reports. Annual resident and relative satisfaction surveys are completed as per company schedule. The last surveys were completed in September 2013. Results are communicated to the relevant committees and staff. Quality improvements from the surveys included contracting a GP for twice weekly visits and improving communication, employing a second care manager, consolidation of the career force training for support staff, trialling cultural dishes to improve food satisfaction, implementing the Eden philosophy, and undertaking a pain project to improvement management of residents pain. Other initiatives introduced are new policies around medication and controlled drug administration and falls prevention project (the RN has commenced a walking group to improve muscle tone and general flexibility for residents). The service has also implemented a buffet breakfast for residents with positive feedback.

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

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

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

The service has a health and safety management system and this includes the appointment of three health and safety representatives (one RN and two healthcare assistants) who have completed health and safety training. Security and safety policies and procedures are in place to ensure a safe environment is provided.

Emergency plans ensure appropriate response in an emergency.

There are comprehensive infection policies and procedures and a restraint/enabler policy and health & safety policy/procedures.

There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has been kept (now on-line) and sessions evaluated.

Resident's files no longer relevant to the service are removed and archived in a locked cupboard (confirmed by the administration officer). Old policies are shredded. The service advised that records are maintained for 10 years. The service is currently introducing storage of files and documents off site with an external security contractor.

There is a policy review date schedule, and terms of reference for the policy review group. New/updated policies/procedures are generated from head office. The quality co-ordinator is responsible for document control within the service ensuring staff are kept up to date with the changes. Copies of new policies are displayed in the staff room with sign off from staff once they have been read and understood and then kept in a folder.

a) Monthly accident/incident/near hit reports are completed by the quality coordinator. Monthly data is collected across the facility including staff incidents and accidents. These are compared with the last month. The monthly reports provided to staff via copies of quality meetings available in the staff room, handovers and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents. Data analysis is also discussed at staff handovers. There is an online database for recording accidents and incidents with medication errors reported separately.

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

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

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

QPS data analysis includes: wound infection rate, skin infection rate, UTI's, respiratory tract infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the three month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken as scheduled during the year.

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

e) The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. Huntleigh Home is currently restraint free with enablers in use.

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

risk. A hazard register is established for the site that includes a hazard register for all areas of the facilities. This is available at the reception area and reviewed at the quality and health and safety meetings. Civil defence procedures are in place and supported by staff training. Security of the facility is checked at night by an external contractor.

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

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

D19.2g Falls prevention strategies include physiotherapy moving and handling assessments, falls risk assessments, use of sensor mats, individual review of residents who fall and physiotherapy reviews.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Ten accident/incident forms were sampled, five from May 2014, four from January – March 2014 and one from September 2013. All show the form has been fully completed and reviewed by a registered nurse. One incident form in January 2013 did not show evidence that neurological observations were completed following a head injury (# link 1.3.6.1). All have on-going review and where appropriate actions to prevent recurrence completed by either the care manager or the facility manager. Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data that is then displayed for staff information. The monthly reports are discussed at all clinical meeting and include the QPS benchmarking indicator results and analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents. Copies of the quality meetings and data analysis is displayed in the staff room for all staff to read.</p> <p>D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. All resident accident/incidents are reported on the correct form. There is documentation in the health status summary of all incidents. These are printed off and attached to a separate sheet in the residents file. The next of kin have been notified in 10 of 10 accident/incidents sampled</p> <p>D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including RNs, pharmacists, podiatrist, physiotherapist and GPs is kept.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (three RN's, two healthcare assistants, one cook, one cleaner, one administrator and one diversional therapist). Each folder had documentation arranged under personal info, correspondence, agreement, education and appraisals. The new manager is currently reviewing all staff files and organising the contents to read systematically. Annual appraisals have been completed for all nine staff files sampled. A comprehensive generic orientation programme is in place that provides new staff with relevant organisational information for safe work practice. This was described by staff and records are sighted. Staff are allocated a full day to complete the generic orientation booklet. The new staff member (interviewed) is supported during their orientation to their work area. There is an implemented specific RN orientation book and RN competencies are completed. RN training is directed by the clinical director for the organisation. RNs attend two PSC professional study days a year that cover the mandatory education requirements and other clinical requirements. All RNs have completed medication competency training in 2013. First aid training is completed for all RNs, two activity staff and the two care managers.

Healthcare assistants attend study days as scheduled to meet mandatory education requirements. The service employs an RN educator/career force assessor to work with students and complete assessments. The quality coordinator also acts as the educator and arranges in house training for healthcare assistants and non-clinical staff. She supports staff through their orientations and sign off when completed. The physiotherapist provides annual manual handling training.

Healthcare assistants and support staff are encouraged and supported to undertake external education. Career force training is supported. The organisations policy is that after three months of employment all healthcare assistants and support staff must be enrolled in Career Force. There are currently 12 healthcare assistants enrolled in Career Force training to complete level three certificates.

The cook and kitchen staff last completed food safety handling in 2013. The cook is currently undertaking level two national certificate in food services.

Two cleaners completed level two training in cleaning and caretaking on the day of the audit. This is reported by the service as being the first facility to complete this level of training.

D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for healthcare assistants. All individual records and attendance numbers are maintained on-line. Monthly reporting of training completed and staff attendance is reported to the regional

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All four families/whanau (two hospital and two rest home) and five residents (four hospital and one rest home) interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the care managers or the manager will be on-call at all times, that at least one staff member on duty (RN) will hold a current first aid qualification. New staff are rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Registered nurses cover each 24 hour period in the rest home and hospital areas am and pm shifts with one RN to cover both areas on the night shift. The healthcare assistant's numbers per area are: Rest home/hospital first floor are five healthcare assistants on the morning shift; Hospital/ ground floor area there are six healthcare assistants on the morning shift; Afternoon shift for the rest home/hospital first floor and hospital/ground floor there are four healthcare assistants in each area. There are three healthcare assistants on night shift. The two care managers (RNs) work 40 hours per week on the morning shift. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type.

Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.

Resident files are protected from unauthorised access by being held in a secure nurse's station within the rest home on the first floor and the hospital area on the ground floor. Support plans and notes are legible and where necessary signed and dated with designation of the person making the entry. Policies contain service name.

Resident records reviewed contain the name of resident and the person completing the form/entry.

D7.1 Entries are legible, dates and signed by the relevant healthcare assistant or registered nurse including designation. Individual resident files kept demonstrate service integration with an allied health section that contains GP notes and the allied health professionals and specialists involved in the care of the resident.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Capital Coast Care Co-ordination centre (needs assessment) ensures all residents are assessed prior to entry for rest home or hospital level of care. A placement authority form is sent to the receiving facility.

The care managers (hospital and rest home) are responsible for the screening of residents to ensure entry has been approved. A pre-admission checklist ensures the potential resident and family are shown around the facility and are introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission.

The information pack includes all relevant aspects of service and associated information such as the H&D Code of Rights and how to access advocacy. There is an admission procedure in place and admission documentation which includes resident and next of kin details. The hospital care manager (interviewed) is able to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable time is arranged for admission. The care managers complete all the admission documentation and relevant notifications of entry to the service. Nine signed admission agreements are sighted. Five residents (one rest home and four hospital) and four relatives (two hospital and two rest home) interviewed state they received all relevant information prior or on admission. The GP is notified of a new admission.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. There have been no declined entries.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.3: 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; D16.5cj; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

The service provides rest home and hospital level of care. On the day of audit there are 25 rest home residents, 40 hospital level of care residents and one rest home respite resident. Downstairs are hospital level of care residents only. There is a mix of rest home and hospital level of care residents upstairs. Hospital residents assessed as lifting hoist transfers are located in rooms downstairs.

D.16.2, 3, and 4: The nine resident files sampled (four rest home, five hospital) identifies the care manager (CM) or registered nurse (RN) completes an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. Nine resident files sampled identified that the long-term support plan is developed within three weeks. There is documented evidence of multidisciplinary reviews (MDT) held three monthly involving the resident/family/whanau, RN keyworker and care staff, recreational officer, medical (including medication review) and where applicable allied health input. The RN amends the long term support plan to reflect on-going changes as part of the review process. Allied health professionals involved in the residents care are linked to the support care plan review such as, dietitian, physiotherapist and podiatrist.

All nine resident files sampled included relative discussion regarding changes to health, incidents, infections, MDT meetings, appointments, transfers to hospital and GP visits, which is identified in the notes by a "relative contact" stamp.

D16.5e: Nine of nine resident files sampled identified that the GP had seen the resident within two working days. It was noted in nine of nine resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status.

The GP (interviewed) is currently providing locum cover for the contracted GP who is on leave. The contracted GP visits the service twice a week to conduct three monthly reviews and see any residents of concern. The GP arranges to meet with families to discuss health concerns and options for treatment and management. The GP is available after hours 24/7 by mobile. The GP is very complimentary about the care the residents receive.

There is a verbal handover period between the healthcare assistant's shifts. There is a verbal and written handover at 9am for all staff on duty (upstairs and downstairs) that ensures staff are kept informed of resident's health status and any significant events.

There is a contracted physiotherapist four hours a fortnight to conduct all resident initial physio assessments, follow-up resident referrals and post falls incidents and exercise programme. The podiatrist is contracted for weekly visits.

Tracer methodology; Hospital

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

Tracer methodology; Rest home resident

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment, first support plan and long term support care plan within the required timeframes. All nine resident files sampled evidenced an initial assessment and support care plan with reference to the information gathered on admission. Relatives and residents advised on interview that assessments were completed in the privacy of their single room. A range of assessment tools is completed on admission if applicable including (but not limited to); a) nutritional and fluid assessment b) falls risk (adapted from Morse) c) moving and handling assessment. d) Braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment g) wound assessment h) skin assessment i) initial physiotherapy assessment.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care as follows: hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest and sleep, communication (ability to use call bell, eyesight, memory, behaviour and mood), loneliness (companions), helplessness (socialisation), spirituality/faith and culture, medical (includes medication and pain management). The support plan reflects the outcomes of risk tool assessments. Each resident has a risk summary form at the front of their file that details the resident's medical problems and alerts such as high falls risk. There is documented evidence of resident/relative/whanau involvement in the support planning process. The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance, food charts and other interventions), incident/accident and infection events summary and correspondence. Short term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short term care plans are pre-printed for chest, urinary and ear infections, nutritional needs and wounds. Short term care plans sighted are for: nutritional needs, chest infection, wounds and fall. Medical GP notes and allied health professional progress notes are evident in the nine residents integrated files sampled. Relatives interviewed are positive and complimentary about the staff, clinical and medical care provided. D16.3k, Short term care plans are in use for changes in health status. D16.3f; Nine out of nine resident files reviewed identified that family have been involved in the support plan process.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: <p>Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. .</p> <p>D18.3 and 4 Dressing supplies are available and the treatment rooms are well stocked. All staff report that there are adequate continence supplies and dressing supplies. Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, and length of time wound present, blood supply, any infection /systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound assessment and management plans and wound progress notes are in use for wound management. However there is an improvement required around wound care documentation and interventions for pressure area management.</p> <p>The GP is notified of all chronic and non-healing wounds. The CM was able to describe the referral process to access the wound nurse specialist through the DHB. Wound management is included in the PSC study days held annually.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, wounds and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed through the DHB and the continence product representative.</p> <p>Behaviour management is described in the unusual or escalating behaviour management plan which is reviewed by the multidisciplinary team (GP, RN, DT) three monthly. Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The community psychogeriatric nurse visit residents who are under the service and is readily available for advice, resources and education. A health status summary held in the resident's record records any significant events, investigations, GP visits and outcomes.</p> <p>Pain assessments are completed for residents on regular or prn pain relief. Pain assessments include non pharmacological strategies. Pain assessments are reviewed every three months and initiated for new or exacerbation of chronic pain. Pain monitoring is completed pre and post analgesia as evidenced on the pain monitoring forms in the medication folders.</p> <p>The contracted physiotherapist completes resident initial moving and handling assessments and reviews three monthly. The physiotherapist is involved in post falls</p>

assessments, exercise programmes and staff education. Falls prevention strategies include physiotherapy moving and handling assessments, falls risk assessments, use of sensor mats, individual review of residents who fall and physiotherapy reviews. There is an improvement required around neurological observations post head injury.

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

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

Attainment and Risk: PA Moderate

Evidence:

Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, and length of time wound present, blood supply, any infection /systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound assessment and management plans and wound progress notes are in use for wound management. The GP is notified of all chronic and non-healing wounds. The CM was able to describe the referral process to access the wound nurse specialist through the DHB. Wound management is included in the PSC study days held annually.

The contracted physiotherapist completes resident initial moving and handling assessments and reviews three monthly. The physiotherapist is involved in post falls assessments, exercise programmes and staff education. Falls prevention strategies include physiotherapy moving and handling assessments, falls risk assessments, use of sensor mats, individual review of residents who fall and physiotherapy reviews.

Finding:

(i)The wound assessment for one sacral pressure area is incomplete (no date, signature or designation). Pressure area interventions are not documented on the short term or long term care plan. (ii) There is no wound assessment or management plan for a heel pressure area. The change of dressing for another sacral pressure area is not recorded as completed at the required frequency. (iii) One incident form in January 2013 did not show evidence that neurological observations were completed following a head injury.

Corrective Action:

(i)Ensure pressure area interventions are documented in the care plan. (ii) Ensure wound assessments and wound management plans are completed. Ensure treatments and/or change of dressings occur at the required frequency. (iii) Ensure neurological observations are completed following head injury.

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

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

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

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

Attainment and Risk: CI

Evidence:

The qualified diversional therapist (DT) has twelve years' experience working with PSC and is an Eden Champion. PSC provide a two day course annually for DTs. The DT attends peer support meetings of the Wellington region recreational officers. She also attends relevant on-site education and training and holds a current first aid certificate. The DT is employed from 9am to 5pm Monday to Friday. A recreation assistant works 20 hours in the downstairs hospital unit. A vacancy for 30 hours per

week will see the programme extended to provide additional activities in the hospital unit and cover Saturdays.

There are separate programmes for upstairs (mostly rest home level) and downstairs (all hospital level) that meets the group and individual recreational needs of both consumer groups. One on one activities occur for residents unable to join in group activities or choose not to participate in activities. There are 20 volunteers involved in the activity programme who assist with a variety of activities and outings. HCAs are also actively involved in the theme days and festive occasions. There are a number of community visitors and entertainers including school and kindergarten children, university students, community choir, musicians, pet therapy, SPCA and musical entertainers. There are weekly van outings. There is a wheelchair hoist in the van. Outings include attending Opportunity, good companion's community group, library, shopping and interesting places such as botanical gardens. Activities included in the programme are newspaper reading, ball games, floor games (bowls, skittles), bingo and quizzes, short stories, baking, craft, music and happy hour. Interdenominational church services and Catholic communion are held weekly. PSC have a contracted chaplain to provide individual spiritual and support services for the residents.

The residents have the opportunity to provide feedback on the activities, outings and entertainment at their two monthly meetings and through resident surveys. There are a number of lounges, open plan dining areas and large recreational rooms upstairs and downstairs where group and individual activities can take place.

The DT meets and greets new residents and completes a life review in consultation with the resident/family/whanau as appropriate. Individual recreational plans are developed with the resident goals documented. The activity plan is reviewed three monthly with the RNs and at the same time as the care plan review. The activities programme is an area of continuous improvement.

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

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

Attainment and Risk: CI

Evidence:

There are separate programmes for upstairs (mostly rest home level) and downstairs (all hospital level) that meets the group and individual recreational needs of both consumer groups. One on one activities occur for residents unable to join in group activities or choose not to participate in activities. There are 20 volunteers involved in the activity programme who assist with a variety of activities and outings. PSC have a contracted chaplain to provide individual spiritual and support services for the residents.

Finding:

Residents participate in everyday activities such as feeding, baking, outings for shopping and caring for the resident cats and budgies. The Eden alternative has been introduced into the home with staff actively participating and supporting new initiatives. HCAs are also actively involved in the theme days, festive occasions and one on one activities. Families are encouraged to attend activities, outings and entertainment with their relative. Eden "moments" are recorded in the resident progress notes. There are a number of volunteers involved in visiting and assisting with various activities. The volunteers continue to build a rapport with the residents. There are Duke of Edinburgh volunteers who spend individual time with residents playing scrabble, discussions, and assists with cooking, gardening, reading and board games. One volunteer plays violin and piano in the weekends. Residents of Asian ethnicity have a volunteer who visits does Reiki massage for them. One volunteer who speaks fluent Russian regularly visits a Russian resident interpreting and conversing with the resident. The volunteer accompanies the resident to activities on the programme so that they may participate in the activities as desired. University students visit and have embraced the "adopt a resident" initiative. Residents particularly enjoy the interaction with young people including school and kindergarten children who write them letters.

The chaplain (interviewed) visits the service twice weekly and more often as required for spiritual and non-spiritual support for the residents. He spends time with families and residents offering on-going support. There is a chaplain referral notebook and regular communication with the DT. The chaplain records visits in the resident notes. He has conducted resident funerals and blesses rooms within 24 hours. The chaplain also provides support to staff especially during palliative cares, dying and death of residents.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Three monthly multidisciplinary team (MDT) evaluations of the support plan are conducted and involve the GP, RN, HCA's, recreational officer, resident/family/whanau input. The written review form includes general recordings, weight and any issues to be discussed with the GP, medication chart review, medical examination conducted and GP monthly or three monthly visits indicated. The HCA keyworkers for the residents are consulted and have input into the review of the support plans as described by seven HCAs interviewed. The resident/family are notified of the review and invited to attend. The long term support plan is amended with each review if there are changes. The relative contact form has written evidence of discussion held with families regarding care plan reviews. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are evidenced in use. Short term support plans are reviewed regularly with problems resolved or added to the long term support plan if an on-going problem.

D16.4a Care plans are evaluated three monthly more frequently when clinically indicated.

ARC D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; support worker for chronic fatigue syndrome society, physiotherapy, radiotherapy, ear health, infectious disease physician, needs assessment co-ordination service, district nurses, dietitian, orthopaedics and community psychiatric nurse There is evidence of GP discussion with families regarding referrals for treatment and options of care. D16.4c; On the day of audit the needs assessor was assessing a respite assessment for hospital level of care. D 20.1 Discussions with the CM identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian, speech language therapist, occupational therapist, psychiatric nurse and other allied health professionals.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: The CM interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, and GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation is sighted in residents record recently transferred back to the facility. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. An end of service checklist is completed on transfer or death of a resident.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies and processes in place that describe medication management. The supplying pharmacy delivers all pharmaceuticals, monthly blister packs and prn blister packs. The returns are kept in the locked medication room until collected. Regular medications and prn medications are checked and signed on the back of the blister pack on delivery. All PRN medications are checked for expiry dates monthly. Any discrepancies are fed back to the pharmacy.

The CM, RN's nurses administering medications have completed a comprehensive medication competency the last year. Annual medication education is attended. Senior HCA's who are the second person to check controlled drugs, complete a medication competency. RNs have syringe driver competency and complete annual refreshers at the hospice as they fall due.

The two medication rooms viewed are keypad entry. Medication rooms contain adequate supplies of pharmaceuticals, treatments, the controlled drug safe and the medication trolley. The controlled drug (CD) stock is checked and signed in the CD register weekly. There is a six monthly pharmacy audit last March 2014. CD's administered are signed by two medication competent staff on the signing administration sheet. Standing orders are current. There are three self-medicating residents including one respite resident. A self-medication assessment has been completed for each resident and is reviewed three monthly by the RN and GP. The resident has a signing sheet in the bedroom that is checked by the RN each shift. The medications are stored safely in the bedroom. Eye drops are dated on opening. Medication fridges have temperatures monitored weekly and are within the acceptable range. The RN checks the oxygen and suction weekly (signing sheet sighted). Emergency medications (adrenaline, glucagon) and palliative care medications are available in the hospital medication room. Approved containers are used for the disposal of sharps.

Eighteen resident medication charts sampled identified all charts have recent photo identification (March 2014) and allergies/adverse reactions noted. There is a staff alert form used for changes in medication charts. There are no signing gaps in the signing administration sheets. All prn medications signed on the prn administration record are dated and timed.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
<p>Evidence:</p> <p>Food services policies and procedures manual is in place. There is a qualified cook and kitchen hand on duty each day from 7am to 3.30pm to prepare, cook and serve the main midday meal. There is an afternoon kitchen hand 1-8pm who assists with the tea meal and ensures the kitchen and dining room cleaning schedules are completed each day (sighted).</p> <p>There is a five weekly summer and winter menu that is reviewed by the company dietitian. Variations to the menu are recorded. The company dietitian is readily available to the cook by email/teleconference two monthly and at other times for advice if required. The cooks attend the annual PSC peer support group and conference. The cooks use an IT automatic ordering system that is linked to the recipes, menus and number of meals required. Recipes are available on line as well as “specials” week to celebrate special events. There is a vegetarian menu available and recently the head cook has been trialling a number of ethnic recipes with positive resident feedback. Currently food service accommodates one vegetarian diet, diabetic diets and pureed meals. The cook follows a special four day menu for one resident. Resident nutritional profiles are sent to the kitchen for new admissions and when there are any resident dietary changes. The cook (interviewed) is knowledgeable in dietary requirements for weight loss management including increased protein, increased milk based desserts, cream and other high calorie foods. There is a dislikes board in the kitchen. Meals are transported in hot boxes to the apartments and served from bain maries in the upstairs and downstairs dining rooms. Cooked food temperatures are conducted and recorded on each meal. Fridge and freezer temperatures within the kitchen and upstairs dining room fridges are monitored twice daily. An improvement is required around the temperature monitoring of facility food fridges.</p> <p>The main kitchen area is well equipped. The equipment has all been serviced. The fire blanket has been checked July 2013. The dry goods are sealed, labelled and off the floor in the pantry. Goods are rotated weekly with the delivery of food orders. Chemicals are stored in locked cupboard. Safety data sheets are available and chemical safety training provided as required. Personal protective equipment is readily available and staff are observed to be wearing hats, aprons and gloves. The service receives feedback directly from the residents, residents meetings, internal audits and resident satisfaction surveys. There is good communication between the food services and the clinical areas and the cooks are informed of any resident's dietary changes.</p> <p>D19.2 Staff have been trained in safe food handling and hygiene through the hospitality services industry (HIS), chemical safety and other relevant in-service.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Cooked food temperatures are conducted and recorded on each meal. Fridge and freezer temperatures within the kitchen and upstairs dining room fridges are monitored twice daily.
Finding: There are facility fridges used for the storage of residents foods. There is no evidence of temperature monitoring for the fridges.
Corrective Action: Ensure all fridges used for the storage of resident foods are temperature monitored.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemicals supplies are kept in a locked areas. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. An automatic dispensing unit is in place for the refilling of chemical bottles. Waste management contractors collect the maxi-bin twice weekly. Recycling bins are collected twice weekly. All infectious material is double bagged. Approved containers are used for the safe disposal of sharps. Staff have attended chemical safety education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The building holds a current building warrant of fitness which expires 27 November 2014. The service is meeting the relevant requirements as identified by relevant

legislation, standards and codes. The facility is purpose built with 42 bedrooms on the first floor (mix of hospital and rest home) and 29 hospital level rooms on the ground floor. The lift can accommodate an ambulance trolley.

The physical environment with wide corridors and hand rails allow for easy access to communal areas and promotes independence for residents with mobility aids. There is a communal dining, kitchenettes, recreational room and lounges in the upstairs and downstairs areas for quiet activities and private meetings with family/visitors.

The maintenance person is contracted for twenty hours a week to carry out minor repairs and maintenance, external building maintenance and any internal maintenance and cleaning duties and vehicle maintenance as per the schedules. The maintenance request book is checked daily and signed off as requests are actioned. Planned maintenance includes fire and emergency equipment checks, hot water temperature monitoring (corrective actions sighted) and equipment functional and electrical checks. There are adequate storage areas for hoists, wheelchairs, products and other equipment.

The grounds are tidy, well maintained and able to be accessed safely. Ramps are in place for wheelchair access to the outdoors. There is seating and shaded areas available. There is an internal courtyard. Residing cats and budgies add to the home like environment for the residents.

Electrical equipment is tested and tagged. Clinical equipment is calibrated annually.

ARC D15.3; The seven HCA's interviewed (morning and afternoon shifts, rest home and hospital) and one CM stated that they have all the equipment referred to in support plans necessary to provide care, including hoists (checked June 2013), pressure relieving mattresses and cushions, shower chairs, transfer belts, slippery sams, chair and hoist weighing scales (calibrated August 2013) wheelchairs, sensor mats, gloves, aprons and masks.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All bedrooms are single with hand basins and some with ensuite. There are adequate communal toilets and shower rooms. Two shower rooms are currently being upgraded. The bathroom and toilets have appropriate flooring and handrails. There are vacant/occupied signs and privacy locks. Call bells are available in all toilet/shower areas.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. The hospital rooms are spacious enough to manoeuvre hosts and hospital level lounge chairs. Residents and their families are encouraged to personalise the bedrooms as viewed. Five residents interviewed (one rest home and four hospital) confirm their bedrooms are spacious and they can personalise them as desired. Huntleigh has a rolling maintenance programme that includes an annual re-fit of five bedrooms (re-carpet and electric beds).

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

The facility has open plan dining area, recreational room, large and smaller lounges in each floor with seating placed appropriately to allow for group and individual activities to occur. Residents are observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All personal clothing and laundry is laundered on site. There is a dedicated laundry person for seven and half hours per day seven days a week. There is a defined clean and dirty area of the laundry. The laundry is well equipped and the machinery is serviced six monthly.

Adequate linen supplies are sighted. There are three cleaners on duty each day working five hours each. The cleaner's cupboard containing chemicals is locked. Cleaner's trolleys are well equipped. All chemicals have manufacturer labels. Laundry and cleaning staff are observed to be wearing appropriate personal protective equipment. The environment on the day of audit is clean and tidy. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms. The service has a vax machine for the regular cleaning of carpets. Staff have attended chemical safety training and infection control education.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. Fire drill was last completed in February 2014 and September 2013. The fire service has an approved fire evacuation plan.

D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Huntleigh Home is well prepared for civil emergencies and has civil defence supplies readily available including torches and radios and disposable plates. There are three tank reservoirs of water for use in an emergency and also water stored in containers. There is a portable generator. A barbeque, portable gas cookers and camping stoves are available for cooking. There are emergency food supplies sufficient for three days. This is stored in the kitchen pantry and food rotated to ensure all expired goods are replaced. There are other products for at least three days such as incontinence products and personal protective equipment. There is a store of supplies necessary to manage a pandemic. There are outbreak boxes and trauma boxes readily available. All emergency equipment is checked monthly. There is a lift between the two floors that has appropriate maintenance service and has an emergency bell and emergency box within the lift containing water, food, torch, blanket and toilet paper for emergencies. There is also a seat for residents to sit on. Two ski pads are available at the top of each stairway to safely transport residents down to the ground floor in emergencies

There is an appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible and within easy reach, and are available in resident areas, e.g. bedrooms, communal toilets, ensuite toilet/showers, lounges and dining rooms. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The call bell system including the door bells are connected to display unit in the corridors. Residents interviewed stated their bells are answered in a timely manner. The facility is secured at night and an external security contractor patrols the facility.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: All bedrooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated with ceiling heating and maintained at a comfortable temperature by individual controls. Residents and relatives interviewed

confirm the environment and the bedrooms are warm and comfortable.

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There is a restraint minimisation and safe practice policy that is applicable to the service. Huntleigh home does not support the use of restraint. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.

The service currently has a restraint-free environment. The service has policies and procedures to support of the use of enablers. There are currently 15 hospital residents using enablers (10 bedrails in use as enablers only and five lap belts). There is an enabler co-ordinator for the service who is the care manager (RN) with considerable aged care experience and has been at the service for three years. Enabler consent, assessment and reviews are in place for the four resident files sampled for enabler use. There are currently three residents who are unable to give consent for the use of enablers (two bedrails and two lap belts). The family/whanau or EPOA have given consent. The policy of the service defines enabler as “the term applied to equipment such as bedrails, noodles, and bed wedges, lap/thigh belts used to promote the independence, comfort and safety of the resident”. The policy also documents resident or EPOA request and outlines the process. An online enabler register is maintained. Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. The enabler is reviewed three monthly with the family and GP involved. There is provision for the use of an emergency enabler. Risks associated with the use of enablers have been identified in the assessment and linked to the long term care plan. Enabler co-ordinators within the PSC group meet four times per year. There is peer support available. The senior team is the enabler review committee and six monthly data is provided to the organisation for analysis. Restraint minimisation is included in the healthcare assistants study days and is provided by the enabler coordinator. Challenging behaviour training was completed in 2013 and 21 staff attended.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

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

The infection control coordinator (IC) is a registered nurse who has been at the service for two and a half years. She has been the infection control coordinator for seven months. The infection control coordinator has developed a team including a kitchen representative, a laundry representative and healthcare assistant's representative.

The team meets two monthly. The infection control co-ordinator provides a monthly report to the quality committee. The committee and the governing body are responsible for the development of the infection control programme and its review.

Staff are well informed about infection control practises and reporting. They can contact the RN or infection control co-ordinator if required and concerns can be written in progress notes and the communication book. For after hour's requirements there is an RN on duty 24/7 and the infection control co-ordinator is available if required.

Suspected infections are confirmed by laboratory tests and results are collated monthly.

Each quarter statistics are sent to the Australian QPS benchmarking programme. Summaries/graphs of these results are feedback to Huntleigh Home and compared with other PSC homes of similar size and service.

There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection.

There is a risk factors for nosocomial infection policy, an accidental infectious exposure, TB, management of staff found positive for MRSA, guidelines for staff visiting overseas, risks and exposures for the pregnant healthcare worker, work restrictions for healthcare personnel exposed to or infected with infectious diseases, handling deceased residents with communicable diseases, guidelines for isolation, transferring of residents with an infection, isolation policy, and procedure for when an outbreak of infection occurs. There is evidence (signage) of preventative measures in place to prevent resident exposure to infectious diseases such as Norovirus.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control criteria policy states the infection control coordinator and team member's work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings. The quality committee is made up of a cross section of staff from all areas of the service including; management, clinical, kitchen, cleaning, laundry and maintenance.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The infection control policies and procedures are developed by the organisation and reviewed by an external infection control specialist. The manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI's, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle

stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases.
There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job descriptions, waste disposal, notification of diseases and educational hand-outs.

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: <p>The infection control co-ordinator held this role for her previous employer overseas. She has maintained her skills and knowledge of infection control practice through attendance at monthly PSC infection control nurse peer support meetings. She has also attended DHB seminar for infection control which included a variety of speakers including Bugs Control and DHB speakers. She is scheduled to attend the PSC infection control seminar in June 2014. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, laboratories service, G.P's, and expertise within the organisation and external infection control specialists. The infection control coordinator has recently qualified as a vaccinator to enable her to administer flu vaccinations in the future.</p> <p>The infection control co-ordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and HCA study days that are held annually and as part of the staff study days. The infection control co-ordinator attends all site meetings and provides topical education which is documented in the meeting minutes. A hand hygiene audit of 15 staff was completed by the infection control team in April 2014 and reviewed by the infection control coordinator with full compliance.</p> <p>Resident education is expected to occur as part of providing daily cares. There is evidence of consumer and visitor education around influenza and norovirus.</p>

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

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

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

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

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

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

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

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

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

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and laboratories service that advise and provide feedback /information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available. Individual resident infection control summaries are maintained.

The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility.

All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The staff are kept informed regarding infections, trends, corrective actions and outcomes during handovers, a copy of the quality meeting displayed in the staff room and data analysis graphs displayed in the staff room. The service has attained a continuous improvement rating for infection control surveillance.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: CI

Evidence:

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

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

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

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

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

Finding:

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. In early 2013 the service recognised that UTI numbers had increased and were above the benchmark compared to other facilities. An investigation showed some residents were not drinking sufficient fluids. Water was routinely provided to each resident on the table at lunch time. However healthcare assistants observed that even with encouragement residents frequently did not drink this. Residents indicated they would be more likely to drink juice so juice is now provided to all residents on the lunch table and staff report most residents drink this without prompting and those who don't are happy to drink it when prompted. To further increase fluid intake the service introduced providing ice blocks to residents on hot days. Following these initiatives the September QPS benchmarking data showed a reduction of UTI's by 60% at the facility. The care manager (the infection control coordinator) reports she has continued to monitor UTI rates closely and in August 2013 noted a slight rise. She then provided education to all residents about hand hygiene including washing hands with soap and water and using alcohol gel that is located around the facility, at the September 2013 residents meeting. Following this UTI rates have dropped again in October and November 2013.

Corrective Action:

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