

# Presbyterian Support Central - Longview Home

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Current Status: 29 July 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

Longview rest home and hospital is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 60 residents. On the day of audit, there were 32 rest home residents, and 25 hospital level residents at the facility. There is a comprehensive orientation programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

This audit identified improvements required around performance appraisals, staff attendance at training, implementation of identified interventions, aspects of medicine management and enabler consent.

The service has been awarded two continuous improvements (CI) in respect of promoting resident independence and volunteer and community involvement in the activities programme.

## Audit Summary as at 29 July 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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 29 July 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 29 July 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 29 July 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 low risk.
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### Safe and Appropriate Environment as at 29 July 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 29 July 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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## Infection Prevention and Control as at 29 July 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 29 July 2014

### Consumer Rights

Longview provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. A continuous improvement has been awarded in respect of promoting resident independence.

### Organisational Management

Longview is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support. Attendance does not meet requirements and this is an area of improvement. The staffing policy aligns with contractual requirements and includes skill mixes. There are two required improvements around performance appraisals and staff attendance at training.

### Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. 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 the implementation of identified interventions. 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, crafts, outings and drives. There are strong community links including 30 volunteers and partnership with a local school. The service has been awarded a continual improvement (CI) attainment for volunteer and community involvement in the activity programme.

There are medicine management policies and procedures in place. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. Medication signing sheets sampled are all correct. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly. There is an improvement required around self-medication and the review of 'as required' (prn) palliative care medications.

The company dietitian reviews the five-weekly menu. Food services staff are aware of resident's likes/dislikes and alternative choices are offered. All food services staff are trained in food safety and hygiene.

### **Safe and Appropriate Environment**

Longview rest home and hospital is a purpose built facility. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised, have a hand basin and shared ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, craft and recreational areas, and several lounges and seating areas. 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 is currently one resident using bedrails as enablers. The enabler co-ordinator has a job description and maintains enabler documentation and an online register. There is an improvement required around documentation of risks and enabler consent.

### **Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (nurse manager) is responsible for coordinating education and training for staff. The infection control co-ordinator

has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Presbyterian Support Central
<b>Certificate name:</b>	Presbyterian Support Central - Longview Home
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Longview Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 29 July 2014 <b>End date:</b> 30 July 2014
<b>Proposed changes to current services (if any):</b> .	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	56

## Audit Team

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

## Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed	6	Number of staff interviewed	15	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	16	Total number of staff (headcount)	62	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXXX, 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 Tuesday, 16 September 2014

## Executive Summary of Audit

### General Overview

Longview rest home and hospital is part of the Presbyterian Support Central (PSC) organisation. The facility provides rest home and hospital level care for up to 60 residents. On the day of audit, there were 31 rest home residents, one rest home private convalescence resident and 25 hospital level residents at the facility. There is a comprehensive orientation programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

This audit identified improvements required around performance appraisals, staff attendance at training, implementation of identified interventions, aspects of medicine management and enabler consent. The service has been awarded two continuous improvements (CI) in respect of promoting resident independence and volunteer and community involvement in the activities programme.

### Outcome 1.1: Consumer Rights

Longview provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. A continuous improvement has been awarded in respect of promoting resident independence.

### Outcome 1.2: Organisational Management

Longview is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support. Attendance does not meet requirements and this is an area of improvement. The staffing policy aligns with contractual requirements and includes skill mixes. There are two required improvements around performance appraisals and staff attendance at training.

### Outcome 1.3: Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. 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 is 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 the implementation of identified interventions. 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, crafts, outings and drives. There are strong community links including 30 volunteers and partnership with a local school. The service has been awarded a continual improvement (CI) attainment for volunteer and community involvement in the activity programme.

There are medicine management policies and procedures in place. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. Medication signing sheets sampled are all correct. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly. There is an improvement required around self-medication and the review of 'as required' (prn) palliative care medications.

The company dietitian reviews the five weekly menu. Food services staff are aware of resident's likes/dislikes and alternative choices are offered. All food services staff are trained in food safety and hygiene.

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

Longview rest home and hospital is a purpose built facility. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised, have a hand basin and shared ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, craft and recreational areas, and several lounges and seating areas. 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 maintain 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 is currently one resident using bedrails as enablers. The enabler co-ordinator has a job description and maintains enabler documentation and an online register. There is an improvement required around documentation of risks and enabler consent.

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (nurse manager) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to

determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	1	39	0	5	0	0	0
<b>Criteria</b>	2	84	0	7	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	5
<b>Criteria</b>	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 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Performance appraisals in three of the seven staff files reviewed were overdue for review.	Annual appraisals are completed.	90
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The care manager has not completed a current medication competency. Review of the healthcare assistant tracking sheet includes (but not limited to): a) infection control training – 14 of 30 have the last training date recorded as 2011 (earlier or not at all) b) chemical safety training –	Care manager completes a medication competency and healthcare assistants complete compulsory training days	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				records report attendance 2010 (or no entry) c) challenging behaviour training – 11 of 30 have attendance date 2011 (earlier or not at all) d) restraint/enabler training – 9 of 30 have attendance date 2011 (earlier or not at all)		
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Review of two (of eight) clinical files, and interview surrounding the recent serious event investigation (report currently in draft with the family) indicate benefit in looking at a process review around effective escalation of clinical changes for individual residents: a) serious event –resident slipped down in her wheelchair, care giver was able to support her and another staff member came to assist. She reported pain in her XXX knee over the following days on movement, and was administered paracetamol which nurses reported having good effect. Medical follow up occurred XXXX, the outcome being a fractured left tibia and fibula. b) resident exhibiting challenging behaviour first reported in progress notes 29 June, and reported at least six times up to 28 July. On 28 July a STCP was put in place and referral to the	Ensure clinical changes are reported in progress notes and required assessment/intervention changes are managed in a timely manner.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>NASC for review.</p> <p>c) in June resident was noted as being continent in LTCP. By 8 July there had been two reports of the resident experiencing stress incontinence. At the time of audit there is no evidence of a continence review/reassessment or update in the LTCP (link 1.3.6).</p> <p>d) interview with seven healthcare assistants inform they feel they report resident matters in progress notes, however are not the view of their reports result in care changes for residents.</p>		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	<p>1) There has been no review of the continence assessment for one resident with stress incontinence as reported in progress notes and requiring a change of product. (link 1.3.3.3).</p> <p>2) There is no pain assessment for a resident with pain as reported in progress notes on non-pharmalogical treatment and regular and prn analgesia. 3) Weekly weighs as instructed on the weight chart have not been completed since June 2014. 4) There is no food intake monitoring for a resident with a nutritional score of six.</p>	Ensure risk assessment tools are reviewed to reflect the resident current health status and interventions identified are implemented.	90
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe and timely manner that	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	complies with current legislative requirements and safe practice guidelines.				
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	There are two residents with PRN palliative care medications that have not been reviewed since a) 2011 and b) 2012	Ensure all prn medications are reviewed at least three monthly by the GP	30
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There is no self-medication assessment, review or monitoring in place. The medication chart does not identify the inhaler the resident self-medicates.	Ensure self-medication procedures are implemented as per policy.	60
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 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.	PA Low	1) The enabler consent form has been signed by the EPOA. There is no evidence of the resident being declared incompetent to make a voluntary decision. 2) The risks associated with the use of the enabler have not been linked to the residents care plan.	1) Ensure consent for the use of an enabler is voluntary. 2) Ensure risks associated with the use of enabler is linked to the resident care plan.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.1.3.6	Services are provided in a manner that maximises each consumer's	CI	To demonstrate an ongoing commitment to the intent of this criterion a project that was evidenced as being underway at the February 2013 surveillance audit

Code	Name	Description	Attainment	Finding
		independence and reflects the wishes of the consumer.		<p>is the starting point. Evidence from that audit report informs the service current annual quality projects and action plans have been developed for 2012/13 to address resident/relatives survey, recreation, staff survey and others'. At this time the service would have received the 2012 results from the resident/relative satisfaction survey. This survey reported an overall satisfaction with the service of 85.21%, noting all areas within the survey scored above 79%. The service developed a quality improvement plan around aspects of feedback and monitored progress through the quality meetings (monthly) and monthly staff meetings. The survey (annual) was completed again in September (2013). The 2013 survey informed 87.53% of respondents informed overall 'satisfaction' with the service (an increase on the previous year of 85.21%). It was also noted a significant improvement had been made (over 5%) around food services. Longview management team was runner up at the 2013 PSC recognition at Quality and Innovation awards based on the outcome of this initiative. In addition resident feedback from this audit would suggest the service continues to be resident focused with resident interviews (six) informing staff are respectful and relatives (three) mentioning the 'atmosphere' of the service. Of particular note is the direct involvement of service staff in managing complaints (2014). One complainant in particular reported issues with food services, and the complaint investigation included the cook working with the resident to agree a resolve. Unfortunately the resident could not be interviewed during the audit – RIP. Review of this information demonstrated the service reviewed the issues raised in the 2012 satisfaction survey, developed and implemented a quality improvement plan and the subsequent satisfaction survey showed overall improvement in satisfaction with the service.</p> <p>From a clinical perspective, a commitment to maximising resident independence continues into the current business planning year. Business planning occurs annually and is guided by the PSC Strategic Framework. Longview has developed a 2014-2015 Business Plan that includes a mission statement and vision for the service. The 2014 - 2015 Business Plan identifies goals for the period and by way of achieving the goal a number of objectives are defined. The objectives are developed under the headings: quality, Eden and health &amp; safety. One of the goals for the period is: Client and resident quality of life is enhanced through assured quality of service. The objectives (as they relate to this narrative) are as follows: quality – reduce harm from falls, Eden – achieve principles 7, 8, 9 and 1, health &amp; safety – improve paths. Progress towards objectives (and therefore goals) is reported monthly both to the regional manager and quality meetings. The objective emerged as the service had been experiencing a number of falls and while individual resident strategies were in place (eg. sensor mats, monitoring), month by month data demonstrated tracking higher than anticipated in terms of the QPS benchmarking data. As an initial step the service analysed the reported incidents in terms of time and location of occurrence and identified incidents were occurring most frequently in</p>

Code	Name	Description	Attainment	Finding
				<p>resident rooms, to this end the 'red rose club' was established during the times most falls were occurring which encouraged residents out of their rooms into a communal setting. At the time of audit the services has noted a reduction in the number of falls, the project is on-going.</p> <p>Longview is progressing on the Eden journey having achieved principles 2, 3, 4, 5, 6 and 10. Eden philosophy underpins projects and initiatives the service develops. Interview with seven healthcare assistants describe how choice is incorporated into resident cares. Interview with residents (two rest home and four hospital) and relatives (one rest home and two hospital) inform staff are respectful. Interviews with residents and family members were positive about the care provided.</p>
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	<p>A volunteer's luncheon was held recently with many being presented with long service certificates. There are 30 volunteers involved in the activity programme during the week and at the weekend. They assist with board games, canine friends, home shop and visit residents on a one on one basis. There are male volunteers who chat and spend time with the men. One of the volunteers is the resident advocate. Two volunteers drive the van (with wheelchair hoist) for outings and mystery trips and carry cell phones to maintain contact with the facility. There are three outings a week for rest home and hospital residents. The programme includes crafts, visiting pets, board games, exercises, Tai Chi, sing-a-long choir, quizzes, various entertainers and movies. The residents were presented with the Enliven quality award recently. Community links are maintained within the community such as a local school who provide cultural support and entertainment for residents. There is a partnership between the local school which includes inter-generation projects including reading to each other and crafts. Community links are maintained with St Vincent de Pauls. The local rotary club takes residents for Sunday drives.</p>

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

PSC Longview has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the two yearly core study days (link 1.2.7). Interview with seven healthcare assistants (who work across rest home and hospital) demonstrate an understanding of the Code. Residents interviewed (two rest home and four hospital) and relatives (one rest home and two hospital) confirm staff respect privacy, and support residents in making choice where able.

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

## 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 pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The quarterly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents interviewed (two rest home and four hospital) and relatives (one rest home and two hospital) inform information has been provided around the Code. The manager and care manager inform an open door policy for concerns or complaints.

D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, advocacy and Health & Disability Commission. The manager, care manager and registered nurses describe discussing the information pack with residents/relatives on admission.

D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

### **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:**

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect (link 1.2.7). Three relatives interviewed stated that the staff are respectful.

A resident satisfaction survey is completed annually (September 2013), Longview management team was runner up at the 2013 PSC recognition at Quality and Innovation awards having used the 2012 survey results and developed quality improvement project on reoccurring problem areas.

Longview has demonstrated a commitment to promoting independence and developing a service that reflects the wishes of the consumer, this can be seen in three key pieces of work – the aforementioned satisfaction survey project, a falls project in process at the time of audit, and the movement towards becoming an Eden registered facility. Based on these three initiatives a CI has been awarded against criterion level. The two projects have included a review process, quality improvement action planning and a change for residents as a result. The Eden philosophy is seen to be an integral part of daily operations.

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. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities.

D4.1a: Eight resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files

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

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

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

**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 1.1.3.6 (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:** CI

**Evidence:**

PSC has an overall quality (and strategic) framework that Longview has used to progress quality initiatives. The service continues to progress towards the goal of becoming an Eden registered home, and because of this the quality initiatives that will be highlighted in the following will demonstrate the service commitment to maximising resident independence and make service improvements that reflect the wishes of residents. Two key projects and the process supporting the work will be summarised in the following.

**Finding:**

To demonstrate an ongoing commitment to the intent of this criterion a project that was evidenced as being underway at the February 2013 surveillance audit is the starting point. Evidence from that audit report informs the service current annual quality projects and action plans have been developed for 2012/13 to address resident/relatives survey, recreation, staff survey and others'. At this time the service would have received the 2012 results from the resident/relative satisfaction survey. This survey reported an overall satisfaction with the service of 85.21%, noting all areas within the survey scored above 79%. The service developed a quality improvement plan around aspects of feedback and monitored progress through the quality meetings (monthly) and monthly staff meetings. The survey (annual) was completed again in September (2013). The 2013 survey informed 87.53% of respondents informed overall 'satisfaction' with the service (an increase on the previous year of 85.21%). It was also noted a significant improvement had been made (over 5%) around food services. Longview management team was runner up at the 2013 PSC recognition at Quality and Innovation awards based on the outcome of this initiative. In addition resident feedback from this audit would suggest the service continues to be resident focused with resident interviews (six) informing staff are respectful and relatives (three) mentioning the 'atmosphere' of the service. Of particular note is the direct involvement of service staff in managing complaints (2014). One complainant in particular reported issues with food services, and the complaint investigation included the cook working with the resident to agree a resolve. Unfortunately the resident could not be interviewed during the audit – RIP. Review of this information demonstrated the service reviewed the issues raised in the 2012 satisfaction survey, developed and implemented a quality improvement plan and the subsequent satisfaction survey showed overall improvement in satisfaction with the service.

From a clinical perspective, a commitment to maximising resident independence continues into the current business planning year. Business planning occurs annually and is guided by the PSC Strategic Framework. Longview has developed a 2014-2015 Business Plan that includes a mission statement and vision for the service. The 2014 - 2015 Business Plan identifies goals for the period and by way of achieving the goal a number of objectives are defined. The objectives are developed under the headings: quality, Eden and health & safety. One of the goals for the period is: Client and resident quality of life is enhanced through assured quality of service. The objectives (as they relate to this narrative) are as follows: quality – reduce harm from falls, Eden – achieve principles 7, 8, 9 and 1, health & safety – improve paths. Progress towards objectives (and therefore goals) is reported monthly both to the regional manager and quality meetings. The objective emerged as the service had been experiencing a number of falls and while individual resident strategies were in place (eg. sensor mats, monitoring), month by month data demonstrated tracking higher than anticipated in terms of the QPS benchmarking data. As an initial step the service analysed the reported incidents in terms of time and location of occurrence and identified incidents were occurring most frequently in resident rooms, to this end the 'red rose club' was established during the times most falls were occurring which encouraged residents out of their rooms into a communal setting. At the time of audit the services has noted a reduction in the number of falls, the project is on-going.

Longview is progressing on the Eden journey having achieved principles 2, 3, 4, 5, 6 and 10. Eden philosophy underpins projects and initiatives the service develops. Interview with seven healthcare assistants (HCA) describe how choice is incorporated into resident cares. Interview with residents (two rest home and four hospital) and relatives (one rest home and two hospital) inform staff are respectful. Interviews with residents and family members were positive about the care provided.

**Corrective Action:**

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

**Criterion 1.1.3.7 (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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **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:**

The Presbyterian Support wide Maori Health plan has been reviewed and updated through the Maori Health plan Wellington Group. The service has access to a cultural advisor with links to local Iwi.

A3.2 Longview has a site specific Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.

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 Health Care Assistant and RN study days for all staff.

D20.1i There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**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 1.1.6: 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:**

The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Discussions with three relatives inform values and beliefs are considered. Discussion with residents two rest home and four hospital) confirm that staff take into account their culture and values.

D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau.  
D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

**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 and Enrolled nurse job descriptions include upholding legal and ethical standards and accountability and responsibility. The orientation booklet provided to staff on induction includes a section on professionalism and standards of conduct, harassment prevention policy and gifts. Understanding the code of conduct and information technology (IT) usage policy is signed as part of orientation. Interview with seven healthcare assistants (who work across both rest home and hospital) could discuss professional boundaries in respect of gifts.

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

### 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

**Evidence:**

Longview has a suite of policies and procedures that are updated as necessary. There is a quality improvement programme that includes performance monitoring against clinical indicators separated into service type – i.e. Rest home and hospital. Longview is benchmarked against other Presbyterian facilities. 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. Policies and procedures cross-reference other policies and appropriate standards. RN's are encouraged and supported to continue education. Health care assistants are supported to complete Career Force or unit standards.

Longview is implementing the Eden Philosophy with achievement of principles 2, 3, 4, 5, 6, and 10. Interview with seven healthcare assistants informed an understanding of the Eden principles. Eden photos posters on notice boards and domestic pets.

ARC A2.2 Services are provided at Longview that adhere to the health & disability services standards.

ARC D1.3 all approved service standards are adhered to.

ARC D17.7c There are implemented competencies for healthcare assistants and registered nurses including but not limited to: insulin administration, medication, manual handling. RNs have access to external training.

Discussions with residents (two rest home and four hospital) and relatives (one rest home and two hospital) were positive about the care they receive. Interview with seven healthcare assistants (who work across both areas) inform they are supported by the RN's and management team.

Improvements since previous audits

Family contacted after all incidents

Staff Training Monitoring – Education Register

STCP signed when resolved. Audit 7/4/14 83.33%  
Wounds progress documented clearly. Audit 7/4/14 83.33%  
Inhalers signed as given  
No medication transcribed  
Refurbishment of chapel 2012  
Refurbishment of further rooms in Tui Wing (Rest Home)

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

### **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:**

There is an open disclosure policy. Discussions with six residents and three family members confirmed they were given time and explanation about services on admission. Resident meetings occur quarterly and the manager and care manager have an open-door policy.

Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Nine incident forms reviewed from June identify family were notified following a resident incident. Interview with seven caregivers (who work across both services) and two RN's inform family are kept informed

D16.4b The residents and three relatives interviewed inform family are informed when the resident health status changes. The service has policies and procedures available for access to interpreter services and staff interviewed were able to describe the process.

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

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D11.3 The information pack is available in large print and advised that this can be read to residents. There has been a relatives and friends information booklet developed. 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.

D 13.3 Eight 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.

The admission agreement has recently been reviewed at an organisational level to make it more user friendly for residents and families.

#### **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, seven HCAs 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 EPOA or family. The GP and RN sign the resuscitation form. Eight resident files sampled (four hospital and four rest home had appropriately signed resuscitation forms.

D13.1 there were eight admission agreements sighted signed appropriately.

D3.1.d Discussion with three families (two hospital and one 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 health care assistants (rest home and hospital), two registered nurses and one care manager identify that consents are sought in the delivery of personal cares and this is confirmed by six residents interviewed (two rest home, four hospital). Resuscitation policy is implemented and there are signed forms in all resident files reviewed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

**Standard 1.1.11: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the manager, and care manager confirm practice. Interviews with residents (two rest home and four hospital) confirm that they are aware of their right to access advocacy.

D4.1d; Discussions with four family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions  
ARC D4.1e. The resident files include information on residents' 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):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D3.1h: Interview with six residents and four relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Interviews with six residents confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.

D3.1.e Discussion with seven healthcare assistants, the activities staff, four relatives and six residents confirm residents are supported and encouraged to remain involved in the community and external groups.

**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:**

There is a complaints policy to guide practice and this is communicated to resident/family. The manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) register that records activity in an on-going fashion. Complaints are discussed at the monthly quality meeting and at the monthly staff meeting. Complaints forms are visible around the facility on noticeboards. There are five recorded complaints for the 2014 year (nine on the 2013 register). Three complaints are from residents, one from a family member and one has resulted in a formal investigation. The report is in the draft report is with the family at the time of audit. Discussion with six residents and three relatives confirm they are aware of how to make a complaint. D13.3h. a complaints procedure is provided to residents within the information pack at entry.

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Enliven PSC have a Strategic Framework (2011-2014). Longview has a 2014-2015 Business Plan and a mission and vision statement defined. The Business Plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. For example a goal is “client and resident quality of life is enhanced through assured quality of service”; a quality objective being: internal audit over 85%; Eden objective “achieving principles 1, 7, 8 and 9; and health and safety objective “improving paths’. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly quality meeting and discussed at staff meetings.

Longview Enliven is part of Presbyterian Support Central and provides rest home and hospital level care for up to 56 residents. On the day of audit there were 31 of 32 rest home residents and 25 of 28 hospital level residents. The manager (registered nurse) has been in post for approximately ten years and prior to this was the care manager at the facility for three years. The manager reports to a regional manager who has been in post five years and oversees seven facilities. The care manager (registered nurse) has been in post 10 years. The senior management team attend a two day peer support training day each year. There are three regional managers meetings a year. The management team (interviewed) feel well supported by the company.

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

### 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:**

There is a registered nurse on duty 24/7. The care manager and two registered nurses alternate on call and the manager is also available. The care manager will cover a temporary absence of the manager. Both the manager and care manager are experienced registered nurses. Support is available from the regional manager. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI 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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

PSC has an overall Quality Monitoring Programme (QMP) and participates in QPS quarterly benchmarking programme - implemented at Longview. The service has a quality coordinator shared between Longview and one other PSC facility.

Quality meetings are held monthly and 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) chaplains monthly report, j) activities monthly report, k) education monthly report, l) maintenance report ( meeting minutes signed). Information is fed back to the monthly staff meetings. A range of other meetings are held at the facility. 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. Improvements since the previous certification audit have been reported (refer evidence 1.1.8).

Feedback on monthly accident and incidents are provided to the quality meeting (refer evidence 1.1.3 re falls project). The service has linked the complaints process with its quality management system – including QPS benchmarking programme (also refer evidence 1.1.13) and feedback through the quality and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control report is completed and provided to quality meeting. Again infections are part of the QPS benchmarking programme. Infections are also being documented on the newly introduced electronic database. The service has a health and safety management system and this includes a health and safety rep (interviewed) who has completed health and safety training. Monthly reports are completed for each service and presented to the quality committee and a quarterly health and safety report is also completed. The report includes identification of hazards and accident/incident reporting and trends are identified. Emergency plans ensure appropriate response in an emergency. The PSC restraint approval group meets six monthly and includes a review. Longview is currently restraint free with one enabler.

The service has policies and procedures to provide 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. 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. 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. The medication management policy includes three yearly competency assessment and annual education for registered staff. Longview is seen to be implementing this policy. D5.4: The service has policies/ procedures to support service delivery.

The Quality Monitoring Programme (QMP) includes an internal audit programme that is being implemented and where a result does not meet the 85% threshold a re-audit is completed for example at Longview: meaningful activity & interventions (completed January (68.25%), re-audit March (76.5%), re-audit May 71.5% and re-audit due July).

Re-audit has also occurred following the nutrition, pressure area, pain, and progress notes audits. The latter had a quality improvement plan put in place focusing on ensuring hospital notes were completed each shift and rest home daily. At the time of audit areas outstanding were being followed up with individuals.

Annual resident satisfaction surveys are completed as per company schedule – refer evidence 1.1.3. There is an organisational staff training programme that is being implemented and based around policies and procedures (link 1.2.7).

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

D19.2g Falls prevention strategies such as sensor mats and individual review of residents who fall.

There are a number of minor discrepancies noted in the quality and risk paperwork during this audit that the service has committed to improving/correcting:

a) Quality improvement form actions signed as completed 9/10/14 (nurses meeting)

b) H&S report has rest home incident data recorded as hospital data

c) April staff meeting has March date on minutes

d) Staff meeting minutes (February) have a corrective action recorded as: staff working long hours at Longview and/or elsewhere; with an action being to report to manager, this action is signed as closed, however the staff meeting minutes from the following month does not report follow-up against matters arising.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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:**

The service collects data relating to adverse, unplanned and untoward events and is linked to the service benchmarking programme. Nine accident/incident forms were reviewed from June/July 2014. All show the form has been completed and reviewed by a registered nurse.

There are two residents whose family members only wish to be contacted following a 'serious' incident. One registered nurse and one enrolled nurse inform there are no standardised definitions for what constitutes 'serious' incidents, rather the decision is based on clinical judgement. Involved family members were not interviewed.

Quality meeting minutes include analysis of incident and accident data (refer evidence 1.1.3) via the monthly incident accident report. QPS benchmarking indicator results and analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents.

D19.3b; There is an incident reporting policy. All resident accident/incidents are reported on the correct form. There is documentation in the health status summary of all incidents. There is a requirement to complete neurological observations following unwitnessed falls and in the forms reviewed this is seen to have been completed.  
D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are human resources policies folder including recruitment, selection, orientation and staff training and development. 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 registered nurses (RN)s, enrolled nurse (EN), pharmacists, podiatrist, physiotherapist and GPs is kept.

Seven staff files were reviewed (care manager/infection control, one registered nurse, one enrolled nurse/health & safety rep, one kitchen, diversional therapist and two healthcare assistants). Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals. Annual appraisals have been completed for four of seven staff files sampled and this is an area of improvement.

A 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. There is an implemented specific RN orientation book and RN competencies are completed. RNs and ENs attend two PSC professional study days a year that cover the mandatory education requirements and other clinical requirements – a schedule is available to see planned attendance. Medication competency is current for staff administering medications, with the exception of the care manager and this is an area of improvement against training. The physiotherapist provide annual manual handling training.

Attendance at core study days is also a requirement for health care assistants (HCA)s. The attendance tracking sheet reviewed as part of the audit identifies a number of healthcare assistants that are overdue for mandatory training and this is an area for improvement.

External education and career force training is supported. The organisations policy is that after three months of employment all caregivers and support staff must be enrolled in Career Force. Literacy and numeracy training is offered.

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

There is a first aid trained staff member on every shift

## 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:** PA Low

**Evidence:**

There are human resources policies including recruitment, selection, orientation and staff training and development processes. Annual appraisals have been completed for four of seven staff files sampled.

**Finding:**

Performance appraisals in three of the seven staff files reviewed were overdue for review.

**Corrective Action:**

Annual appraisals are completed.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Attendance at core study days is also a requirement for HCAs. The attendance tracking sheet reviewed as part of the audit identifies a number of healthcare assistants that are overdue for mandatory training and this is an area for improvement. External education and career force training is supported. The organisations policy is that after three months of employment all caregivers and support staff must be enrolled in Career Force. Literacy and numeracy training is offered. D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for caregivers. All individual records and attendance numbers are maintained on-line. Monthly reporting of training completed and staff attendance is reported to the regional manager and clinical director monthly

**Finding:**

The care manager has not completed a current medication competency. Review of the healthcare assistant tracking sheet includes (but not limited to):

- a) infection control training – 14 of 30 have the last training date recorded as 2011 (earlier or not at all)
- b) chemical safety training – records report attendance 2010 (or no entry)
- c) challenging behaviour training – 11 of 30 have attendance date 2011 (earlier or not at all)
- d) restraint/enabler training – 9 of 30 have attendance date 2011 (earlier or not at all)

**Corrective Action:**

Care manager completes a medication competency and healthcare assistants complete compulsory training days

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows:

Manager and care manager work full time, Monday through Friday. The following is the Monday through Sunday numbers:

AM – 1x registered nurse 7am-3.30pm, 1x registered nurse/enrolled nurse 7am-3.30pm (Monday through Sunday), 4x healthcare assistants 7am-3.30pm, 3x healthcare assistants 7am-1.30pm.

PM – 1x registered nurse 3.00pm-11pm, 1x enrolled nurse 4pm-11pm, 2x healthcare assistants 3pm-11pm, 1x healthcare assistant 4pm-11pm, 1x healthcare assistant 3pm-9pm, 1x healthcare assistant 4pm-9pm.

ND: 1x registered nurse 10.45pm-7.15am, 2x healthcare assistants 11pm-7am.

Note the service has four vacant beds. There is flexibility based on need to add a healthcare assistant 7am-1pm, and/or 4pm-9pm.

Interview with seven healthcare assistants informs there are sufficient staff to meet needs.

#### **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 required timeframes into the resident's individual record. An initial care 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 locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant healthcare assistant or registered nurse including designation.

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

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

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

## Outcome 1.3: Continuum of Service Delivery

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

### Standard 1.3.1: 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:**

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 Manager is 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 registered nurse manager or care manager complete all the admission documentation and relevant notifications of entry to the service. Eight signed admission agreements are sighted. Six residents (two rest home and four hospital) and three relatives (one rest home and two hospital) 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 are no declined entry records.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service provides rest home and hospital level of care for up to 60 residents.

D.16.2, 3, 4: The eight resident files sampled (four rest home, four 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. Eight 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 for hospital residents and six monthly for rest home residents. The RN amends the long term support plan to reflect ongoing changes as part of the review process. Allied health professionals involved in the residents care are linked to the support care plan review such as, dietitian, physiotherapist and podiatrist.

All eight 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: Eight of eight resident files sampled identified that the GP had seen the resident within two working days. It was noted in eight of eight resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced by entry (and GP stamp) in files of residents with more complex conditions or acute changes to health status.

The GP (interviewed) is currently contracted to provide medical services and visits for two hours twice a week. The care manager co-ordinate family meetings with the GP as required to discuss health concerns and options for treatment and management. The GP is available after hours 24/7 by mobile. The GP confirms RN clinical assessments and after hours calls are appropriate. The GP provides training opportunities such as male catheterisation for RNs.

There is a verbal and written handover period between the health care assistant (HCA) shifts that ensures staff are kept informed of resident's health status and any significant events. HCA progress notes are maintained each shift. RNs and enrolled nurses (EN) document notes on the resident health status summary. There is an improvement required around timely management of assessment/intervention changes are managed in a timely manner. There is a temporary physiotherapist who is available as required. The podiatrist is contracted for regular visits.

Four rest home files sampled

Four hospital level files sampled

Tracer methodology;

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

Tracer methodology; Rest home

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Staff could describe a verbal handover at the end of each duty. There is a verbal and written handover period between the health care assistant (HCA) shifts that ensures staff are kept informed of resident's health status and any significant events. HCA progress notes are maintained each shift. RNs and enrolled nurses (EN) document notes on the resident health status summary.

**Finding:**

Review of two (of eight) clinical files, and interview surrounding the recent serious event investigation (report currently in draft with the family) indicate benefit in looking at a process review around effective escalation of clinical changes for individual residents:

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

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

c) in June

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

d) interview with seven healthcare assistants inform they feel they report resident matters in progress notes, however are not the view of their reports result in care changes for residents.

**Corrective Action:**

Ensure clinical changes are reported in progress notes and required assessment/intervention changes are managed in a timely manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

Staff could describe a verbal handover at the end of each duty.

**Corrective Action:**

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

### **Standard 1.3.4: 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 eight resident files sampled (four rest home and four hospital) 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 are available for use 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) physiotherapy assessment (also link 1.3.6.1). The diversional therapist (DT) completes an activity 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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** 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: urinary tract infections (UTI), chest infection, eye infection, skin infection, toothache, wounds, nutritional requirements for weight loss and unusual/escalating behaviour. Short term care plans are evaluated at regular intervals. Medical GP notes and allied health professional progress notes are evident in the eight residents integrated files sampled. D16.3k, Short term care plans are in use for changes in health status. D16.3f; Eight out of eight resident files reviewed identified (by signature) that the resident or family member 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 Low

**Evidence:**

Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.

D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. All staff report that there are adequate continence supplies and dressing supplies. Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, 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 wounds. Chronic wounds are linked to the long term support plan. The GP is notified of all chronic and non-healing wounds. There is evidence of the wound nurse being involved in chronic, non-healing or pressure areas as required. There are two sacral and one heel grade 1 pressure areas and one grade two pressure area of ankle. One heel and one sacrum pressure area (one resident) is hospital acquired. There are adequate pressure area resources. Pressure area intervention included the use of air alternating mattresses, roho cushions and heel protectors. There are short term care plans in place for minor wounds and skin tears. 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. There is an improvement required around continence management.

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 GP initiates any specialist referrals to the mental health services for the older person. A health status summary held in the resident's record records any significant events, investigations, GP visits and outcomes.

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. Chronic pain is linked to the long term and initiated for new or exacerbation of chronic pain. There is an improvement required around pain assessments.

The 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 and equipment assessments, falls risk assessments, use of sensor mats, individual review of residents who fall and physiotherapy reviews and hip protectors. There is evidence of neurological observations completed for unwitnessed falls and post head injury.

There is monthly monitoring of the residents weight and blood pressure. Recordings are reviewed by the GP at the three monthly review. There is an improvement required around weight monitoring.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

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. 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. 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. Chronic pain is linked to the long term and initiated for new or exacerbation of chronic pain. There is monthly monitoring of the residents weight and blood pressure. Recordings are reviewed by the GP at the three monthly review.

**Finding:**

1) There has been no review of the continence assessment for one resident with stress incontinence as reported in progress notes and requiring a change of product. (link 1.3.3.3). 2) There is no pain assessment for a resident with pain as reported in progress notes on non-pharmacological treatment and regular and prn analgesia. 3) Weekly weighs as instructed on the weight chart have not been completed since June 2014. 4) There is no food intake monitoring for a resident with a nutritional score of six.

**Corrective Action:**

Ensure risk assessment tools are reviewed to reflect the resident current health status and interventions identified are implemented.

**Timeframe (days):** 90 (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 21 years' experience working at PSC Longview. She is a registered DT and a representative on the NZDTS board and the president of the regional support group who coordinate the workshops and seminars for DTs. The DT is a roving and workplace career force assessor. She also attends relevant on-site education and training and holds a current first aid certificate. The DT is employed Monday to Friday full-time and has a recreational officer employed for 18 hours a week. Both staff attended a peer support day in March 2014. There are activity policies in place and procedures that cover each activity including resources required.

The rest home/hospital mixed activity programme is held in a number of lounges throughout the facility. The programme commences between 9-10am throughout the day with a 6pm movie and entertainment during the week. There is a large newly opened craft room with kitchenette and residents are observed participating in crafts on the day of audit. There is an on-site chapel and library room. A volunteer's luncheon was held recently with many being presented with long service certificates. There are 30 volunteers involved in the activity programme during the week and at the weekend. They assist with board games, canine friends, home shop and visit residents on a one on one basis. There are male volunteers who chat and spend time with the men. One of the volunteers is the resident advocate. Two volunteers drive the van (with wheelchair hoist) for outings and mystery trips and carry cell phones to maintain contact with the facility. There are three outings a week for rest home and hospital residents.

The programme includes crafts, visiting pets, board games, exercises, Tai Chi, sing-a-long choir, quizzes, various entertainers and movies. The residents were presented with the Enliven quality award recently. One on one activities occur for residents unable to join in group activities or choose not to participate in activities. Community links are maintained within the community such as a local school who provide cultural support and entertainment for residents. There is a partnership between the local school which includes inter-generation projects including reading to each other and crafts. Community links are maintained with St Vincent de Pauls.

The Rose Red Club has been recently formed twice a week in the afternoon for a small group of at risk residents with dementia. The small group is supervised in activities that meet their individual preferences and abilities.

The service has an on-site chapel and churches rotate each Sunday and during the week to provide church services. The chapel has been used for funerals.

The residents have the opportunity to provide feedback on the activities, outings and entertainment at the resident meetings and through resident surveys. The DT meets and greets new residents and completes a Tree of Life in consultation with the resident/family/whanau as appropriate. The Individual recreational plan is developed with the resident goals documented. The activity plan is reviewed with the RNs and at the same time as the care plan review.

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

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

**Attainment and Risk:** CI

**Evidence:**

The rest home/hospital mixed activity programme is held in a number of lounges throughout the facility. The programme commences between 9-10am throughout the day with a 6pm movie and entertainment during the week. There is a large newly opened craft room with kitchenette and residents are observed participating in crafts on the day of audit. There is an on-site chapel and library room.

**Finding:**

A volunteer's luncheon was held recently with many being presented with long service certificates. There are 30 volunteers involved in the activity programme during the week and at the weekend. They assist with board games, canine friends, home shop and visit residents on a one on one basis. There are male volunteers who chat and spend time with the men. One of the volunteers is the resident advocate. Two volunteers drive the van (with wheelchair hoist) for outings and mystery trips and carry cell phones to maintain contact with the facility. There are three outings a week for rest home and hospital residents. The programme includes crafts, visiting pets, board games, exercises, Tai Chi, sing-a-long choir, quizzes, various entertainers and movies. The residents were presented with the Enliven quality award recently. Community links are maintained within the community such as a local school who provide cultural support and entertainment for residents. There is a partnership between the local school which includes inter-generation projects including reading to each other and crafts. Community links are maintained with St Vincent de Pauls. The local rotary club takes residents for Sunday drives.

**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 (hospital) and six monthly (rest home) MDT evaluations of the support plan are conducted and involve the GP, RN, HCA's, DT, 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. 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. Discussion held with families regarding care plan reviews is identified by a "relative contact stamp" in the health status summary. 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 ongoing 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; needs assessment co-ordination service, psycho-geriatrician, physiotherapy, dietitian, urology, eye clinic, dermatology, orthopaedics and wound nurse.

There is evidence of GP discussion with families regarding referrals for treatment and options of care.

D16.4c; There is evidence of a rest home resident re-assessed for hospital level of care and a recent referral to the psychogeriatric team for re-assessment for higher 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):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

**Attainment and Risk:** PA Low

**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 against the medication chart and signed off on the checking sheet. Any discrepancies are fed back to the pharmacy. There is one central locked medication room that holds the pharmaceutical supplies and the rest home and hospital medication trolleys. The controlled drug safe is kept in a locked room off the nurse's station.

The RN's and senior HCAs administering medications have completed a comprehensive medication competency within the last year. The CM has not completed a medication competency (link 1.2.7.5). Annual medication education is attended. RNs have syringe driver competency and complete annual refreshers at the hospice as they fall due. Syringe driver medication is made on site. The hospital holds a bulk supply of controlled and palliative care drugs. The controlled drug (CD) stock is checked weekly. There is a six monthly pharmacy audit last July 2014. Standing orders are not used. There is one self-medicating resident (inhaler) in the rest home. There is an improvement required around self-medication management. Medication fridges have temperatures monitored weekly and are within the acceptable range. The RN checks the oxygen and suction weekly (signing sheet sighted). Medical equipment is checked annually. Emergency medications (adrenaline, glucagon) and palliative care medications are available and checked regularly. Approved containers are used for the disposal of sharps.

Sixteen pharmacy generated resident medication charts sampled identified all charts have recent photo identification (dated) and allergies/adverse reactions noted. There are no signing gaps in the signing administration sheets sampled. All prn medications signed on the prn administration record are dated and timed. There is an improvement required around the review of palliative prn medications.

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

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

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

**Attainment and Risk:** PA Low

**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 against the medication chart and signed off on the checking sheet. Any discrepancies are fed back to the pharmacy. There are no signing gaps in the signing administration sheets sampled. All prn medications signed on the prn administration record are dated and timed.

**Finding:**

There are two residents with PRN palliative care medications that have not been reviewed since a) 2011 and b) 2012

**Corrective Action:**

Ensure all prn medications are reviewed at least three monthly by the GP

**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:** PA Low

**Evidence:**

There is one self-medicating resident (inhaler) in the rest home.

**Finding:**

There is no self-medication assessment, review or monitoring in place. The medication chart does not identify the inhaler the resident self-medicates.

**Corrective Action:**

Ensure self-medication procedures are implemented as per policy.

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

**Criterion 1.3.12.6 (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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Food services policies and procedures manual is in place. The head cook on duty is in the second year of NZQA apprenticeship through the Hospitality standards industry (HSI). He is supported by a morning and afternoon kitchen hand and three relieving cooks. The head cook trains other food services staff in NZQA unit 167. Breakfast is served in the residents rooms. 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 available to the cook by email and bi-monthly teleconferences. The cooks use an IT automatic ordering system that is linked to the recipes, menus and number of meals required. There is a vegetarian menu available. 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. Resident dislikes are known and alternatives are offered. Dietary requirements including diabetic, normal, soft and pureed are provided. Specialised crockery, utensils and drinking cups are available. Meals are served from bain maries. Cooked food temperatures are taken and recorded weekly and on all chicken meals. Fridge and freezer temperatures are monitored twice weekly. Fridges and freezers have visual temperatures and alarms to alert staff when temperatures are outside of the required range. All facility fridges are monitored weekly. Delivery temperatures are recorded on all chilled/frozen goods. The kitchen is well equipped with a pantry area, chillers, freezers, combi oven and gas hobs. Equipment is serviced six monthly. All foods are rotated on delivery of goods. The dry goods are sealed, labelled and off the floor in the pantry. Chemicals are stored in locked cupboard. Safety data sheets are available. A daily and weekly cleaning schedule is maintained. The maintenance person carries out scheduled cleaning of walls and ceilings. The dishwasher is checked monthly by the contractor. 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. The head cook attends the quality meetings.

D19.2 staff have been trained in safe food handling and hygiene.

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(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 cupboards in service areas. A chemical spills kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. All infectious material is double bagged. Approved containers are used for the safe disposal of sharps. Staff have not attended chemical safety education since 2010 (link 1.2.7.5). 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 21 March 2015. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The facility is purpose built with 60 rooms divided into six wings with a small lounge/conservatory and kitchenette at the end of the wing.

The physical environment with wide corridors allow for easy access to communal areas and promotes independence for residents with mobility aids. There is a communal rest home dining room and hospital dining room, craft room, library and lounges areas for quiet activities and private meetings with family/visitors and an on-site chapel.

The maintenance person is employed across several PSC homes and is on-site once a week and available on call as required. The maintenance person carries out minor repairs and maintenance, external building maintenance and any internal maintenance and cleaning duties as per the schedules. The maintenance request book is checked and signed off as requests are actioned. Planned maintenance includes emergency and civil defence equipment checks, hot water temperature monitoring (corrective actions sighted) and equipment checks. There is adequate storage areas for hoist, wheelchairs, products and other equipment. Electrical equipment is tested and tagged. Clinical equipment is calibrated annually. Preferred contractors are available 24/7.

The grounds and gardens are tidy, well maintained by contractors and able to be accessed safely by residents and have wheelchair access to the outdoors. There is seating and shaded areas available. There is an internal courtyard with raised gardens and a kitchen garden. There is a designated outdoor smoking area.

ARC D15.3; The seven HCA's interviewed (morning and afternoon shifts, rest home and hospital), two RNs and one CM stated that they have all the equipment referred to in support plans necessary to provide care, including four ceiling hoists (from family donation), standing and lifting hoists (checked May 2013), pressure relieving mattresses and cushions, tilting shower chair, transfer belts, slidy sams, chair scales (calibrated August 2013) wheelchairs, electric beds, 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 shared ensuites. There are adequate communal toilets and shower rooms. The shared ensuites 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 for rest home or hospital level of care. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. The bedrooms rooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide doors for ambulance or bed entry//exit. Residents and their families are encouraged to personalise the bedrooms as viewed. Six residents interviewed (two rest home and four hospital) confirm their bedrooms are spacious and they can personalise them as desired. Longview has a maintenance and refurbishment plan that includes six bedrooms to be refurbished this year.

**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 two dining rooms, open plan main lounge room, craft room, large and smaller lounges in each wing 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. There is a library area and recreational area with a bowling table.

**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 five and half hours per day seven days a week. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped and the machinery last serviced May 2014. .

Adequate linen supplies are sighted. Afternoon HCAs deliver clothing to the rooms. Chemicals are stored in a locked chemical room. There are two cleaners on duty each day working four 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. There is a daily and monthly room clean schedule. The service has a vax machine for the regular cleaning of carpets.

### **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. There is an approved evacuation plan (letter dated 20 June 2000). Fire evacuations are held six monthly and the last drill was completed 10 February 2014. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back-up. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and personal protective equipment (PPE) are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner. A test of a resident call bell demonstrated an appropriate response time (one minute and 10 seconds).

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

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All bedrooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas are heated with heat pumps and maintained at a comfortable temperature by individual controls. There is gas radiator heating along the corridors and in the resident bedrooms. 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):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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### **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** PA Low

**Evidence:**

There is a restraint minimisation and safe practice policy that is applicable to the service. Longview rest home and hospital 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 is an enabler co-ordinator for the service who is the care manager (RN) with a signed job description. There is currently 1 hospital resident using an enabler (bedrails).

Enabler consent, assessment and reviews are in place for the one resident file sampled with enabler use. The EPOA has given consent however there is no evidence the resident has been declared incompetent to make a voluntary decision. An improvement is required around enabler consent. 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. There is provision for the use of an emergency enabler. Risks associated with the use of enablers have been identified in the assessment. The risks have not been linked to the resident care plan. This is an area for improvement. Enabler co-ordinators within the PSC group meet four times per year and attend an annual training day (September 2013). There is peer support available. Restraint minimisation is included in the health care assistants study days and is provided by the enabler coordinator as part of the orientation process. Challenging behaviour training and restraint/enabler training has not occurred since 2011 (link 1.2.7.5). The enabler co-ordinator provides a monthly report to the quality meeting.

### 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:** PA Low

**Evidence:**

Enabler consent, assessment and reviews are in place for the one resident file sampled with enabler use. The EPOA has given consent however there is no evidence the resident has been declared incompetent to make a voluntary decision. An improvement is required around enabler consent. 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. There is provision for the use of an emergency enabler. Risks associated with the use of enablers have been identified in the assessment.

**Finding:**

1) The enabler consent form has been signed by the EPOA. There is no evidence of the resident being declared incompetent to make a voluntary decision. 2) The risks associated with the use of the enabler have not been linked to the residents care plan.

**Corrective Action:**

1) Ensure consent for the use of an enabler is voluntary. 2) Ensure risks associated with the use of enabler is linked to the resident care plan.

**Timeframe (days):** 90 (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

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

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

ARC D5.4e ARHSS D5.4e

**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 and summaries of these results are feedback through the quality and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator is care manager (registered nurse) and 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 informed about infection control practises and reporting. Suspected infections are confirmed by laboratory tests and results are collated monthly. 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 practitioner and committee members 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. The facility also has access to an infection control nurse specialist, public health and GP's.

### 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:**

D 19.2a: The infection control (IC) manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed 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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control co-ordinator has maintained her skills and knowledge of infection control practice through attendance at the annual PSC infection control nurse peer support day which included a variety of speakers including Bugs Control and DHB speakers. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, G.P's, and expertise within the organisation and external infection control specialists. 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 (link 1.2.7). Resident education is expected to occur as part of providing daily cares.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator 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 liaison with the GP and Med lab 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. All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.

**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.

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

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