

Parkwood Trust Incorporated

Current Status: 10 September 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

Parkwood Trust Incorporated is a charitable trust set up in the early 1970's. The facility provides rest home and hospital level care to 76 residents, 42 at rest home level and 34 at hospital level care. Since the last on-site audit there have been no additions to the facility.

There are no areas requiring improvement identified and there are six areas of continuous improvement. These relate to a six week post admission survey process, the organisation's evaluation of progress against its quality goals, a recent training initiative in the fundamentals of palliative care, the evaluation of activities and recreation, continuous monitoring and evaluation of satisfaction with meals, an initiative to reduce infections and subsequent antimicrobial usage.

Audit Summary as at 10 September 2014

Standards have been assessed and summarised below:

Key

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

Consumer Rights as at 10 September 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 10 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 10 September 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 10 September 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 10 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 10 September 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 10 September 2014

Consumer Rights

Care provided to residents at Parkwood Lodge is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Parkwood Lodge does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required. Residents receive a high standard of care and assistance.

Residents feel safe, there is no sign of harassment or discrimination. Staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events. A local independent Health and Disability Service Advocate is known to the service and is accessible if required.

Parkwood Lodge encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible. An area of continuous improvement is identified around informed consent, whereby a post admission survey identifies resident deficits in information and knowledge.

There is readily accessed complaints process which is visible throughout the facility. The complaints register is managed by one of the quality managers and is current, up-to-date and meets the requirements of these standards.

Organisational Management

There is a board of trustees comprising of residents and non-residents. All have a range of relevant experience and knowledge to the management of the financial asset and the implementation of the Trust's mission "to provide the service, surroundings and care that are second to none". There is a general manager, who with a senior management team in 'The Lodge' (the aged care facility) run the day to day operations of the care facility.

There is a comprehensive quality management system which incorporates document management and control, event report and data analysis, evaluation of data over time, corrective action planning and implementation and an effective risk management system. All adverse events are reported and managed appropriately. There is a culture of reporting and open disclosure of events. An area of continuous improvement is noted in relation to the organisation's annual evaluation of its progress against its quality goals. This includes input from residents via regular residents' meetings, as well as monthly quality management meetings and internal audit systems.

The nurse manager is responsible for the recruitment and appointment of all staff with oversight by the general manager. Human resources management systems are in place which follow good employment practices. There is an effective system of staff training from induction and orientation through to ongoing development. Another area of continuous improvement is noted in relation to a training initiative in Hospice New Zealand's fundamentals of palliative care run by Mary Potter Hospice. This has contributed to an increase in staff competence in supporting residents at the end of life and a decrease in hospital and hospice admissions out of Parkwood.

There are safe staffing levels maintained across the rest home and hospital areas of the facility. In the hospital this includes 24 hour nursing staff, and a mix of enrolled nurses and care givers who hold relevant qualifications. Domestic and kitchen staff are similarly qualified and there is a commensurate level of these staff members to support a safe and comfortable environment.

Residents' admission information is accurately recorded, and all information is securely stored and not accessible to the public. Service providers use up to date and relevant consumer records.

Continuum of Service Delivery

A 'Welcome to Parkwood Lodge' information pack for residents contains information on all aspects of service, entry criteria, inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy. There is evidence that residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis.

An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. The active involvement of residents in ensuring the programme meets their needs is identified as a process demonstrating continuous improvement.

Well defined medicine policies and procedures guide practice and practices sighted are consistent with these documents.

The menu has been reviewed as meeting nutritional guidelines by a registered dietician, with any special dietary requirements and need for feeding assistance or modified equipment recorded and being met. Residents have a role in menu choice. The existence of processes to ensure residents' ongoing satisfaction with meals is also an area of continuous improvement.

Safe and Appropriate Environment

Parkwood is a purpose built facility first constructed in the late 1970s with further additions in the 1980s. It is well maintained and is in good condition. The environment promotes safety and mobility and residents are observed moving about the facility independently during the audit visit. Rest home level care is provided in apartments, either individual or double apartments for couples. Most hospital level care is provided in rooms, although some is provided in apartments. All rooms and apartments have their own bathrooms with showers and toilets. All rooms have externally facing windows which open onto gardens. Rooms are light and spacious, as is the whole facility.

There is a current building warrant of fitness and an approved evacuation scheme, which is regularly practiced.

There are procedures for the management of waste and hazardous substances and staff receive appropriate training and adequate supplies of personal protective equipment. There are effective procedures for all cleaning and laundering, and these are monitored regularly and frequently.

Restraint Minimisation and Safe Practice

There are well developed policies and procedures which guide staff in the practice and safe use of restraints and enablers. There is a restraint committee which includes a general practitioner,

senior nurses in the facility, a resident advocate and the restraint coordinator. Residents and family members are involved in decisions on the use of restraints and enablers, however there is an active focus on restraint minimisation.

When restraints are used there is assessment which includes consent, monitoring, evaluation and review of restraint use. The organisation carefully monitors its use of restraints and actively looks to reduce restraints wherever possible. Enablers are voluntary. Staff interviews and file reviews confirm the stated philosophy of restraint minimisation.

Infection Prevention and Control

The service is able to demonstrate it provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control co-ordinator/Nurse Manager reporting directly to the general manager who reports to the board. There is a clearly defined infection prevention and control programme for which external advice and support is sought.

The infection control nurse/Nurse Manager and the infection control committee is responsible for this programme, including education and surveillance. Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. An initiative evidencing a reduction in infections and subsequent anti-microbial usage provides evidence of continuous improvement. Surveillance results are reported through all levels of the organisation, including governance.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Parkwood Trust Incorporated
Certificate name:	Parkwood Trust Incorporated
Designated Auditing Agency:	The DAA Group Limited
Types of audit:	Certification Audit
Premises audited:	Parkwood Retirement Village
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 September 2014 End date: 11 September 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	76

Audit Team

Lead Auditor	XXXXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXXXX	Total hours on site	16	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXX			Hours	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52
Number of residents interviewed	5	Number of staff interviewed	14	Number of managers interviewed	8
Number of residents' records reviewed	5	Number of staff records reviewed	12	Total number of managers (headcount)	8
Number of medication records reviewed	10	Total number of staff (headcount)	110	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXXX, Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group 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)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Tuesday, 7 October 2014

Executive Summary of Audit

General Overview

Parkwood Trust Incorporated is a charitable trust set up in the early 1970's. The facility provides rest home and hospital level care to 76 residents, 42 at rest home level and 34 at hospital level care. Since the last on-site audit there have been no additions to the facility.

There are no areas requiring improvement identified and there are six areas of continuous improvement. These relate to a six week post admission survey process, the organisation's evaluation of progress against its quality goals, a recent training initiative in the fundamentals of palliative care, the evaluation of activities and recreation, continuous monitoring and evaluation of satisfaction with meals, an initiative to reduce infections and subsequent antimicrobial usage.

Outcome 1.1: Consumer Rights

Care provided to residents at Parkwood Lodge is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Parkwood Lodge does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required. Residents receive a high standard of care and assistance.

Residents feel safe, there is no sign of harassment or discrimination. Staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events. A local independent Health and Disability Service Advocate is known to the service and is accessible if required.

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There is readily accessed complaints process which is visible throughout the facility. The complaints register is managed by one of the quality managers and is current, up-to-date and meets the requirements of these standards.

Outcome 1.2: Organisational Management

There is a board of trustees comprising of residents and non-residents. All have a range of relevant experience and knowledge to the management of the financial asset and the implementation of the Trust's mission "to provide the service, surroundings and care that are second to none". There is a general manager, who with a senior management team in 'The Lodge' (the aged care facility) run the day to day operations of the care facility.

There is a comprehensive quality management system which incorporates document management and control, event report and data analysis, evaluation of data over time, corrective action planning and implementation and an effective risk management system. All adverse events are

reported and managed appropriately. There is a culture of reporting and open disclosure of events. An area of continuous improvement is noted in relation to the organisation's annual evaluation of its progress against its quality goals. This includes input from residents via regular residents' meetings, as well as monthly quality management meetings and internal audit systems.

The nurse manager (NM) is responsible for the recruitment and appointment of all staff with oversight by the general manager. Human resources management systems are in place which follow good employment practices. There is an effective system of staff training from induction and orientation through to ongoing development. Another area of continuous improvement is noted in relation to a training initiative in Hospice New Zealand's fundamentals of palliative care run by Mary Potter Hospice. This has contributed to an increase in staff competence in supporting residents at the end of life and a decrease in hospital and hospice admissions out of Parkwood.

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Residents' admission information is accurately recorded, and all information is securely stored and not accessible to the public. Service providers use up to date and relevant consumer records.

Outcome 1.3: Continuum of Service Delivery

A 'Welcome to Parkwood Lodge' information pack for residents contains information on all aspects of service, entry criteria, inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy. There is evidence that residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis.

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Outcome 1.4: Safe and Appropriate Environment

Parkwood is a purpose built facility first constructed in the late 1970s with further additions in the 1980s. It is well maintained and is in good condition. The environment promotes safety and mobility and residents are observed moving about the facility independently during the audit visit. Rest home level care is provided in apartments, either individual or double apartments for couples. Most hospital level care is provided in

rooms, although some is provided in apartments. All rooms and apartments have their own bathrooms with showers and toilets. All rooms have externally facing windows which open onto gardens. Rooms are light and spacious, as is the whole facility.

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There are procedures for the management of waste and hazardous substances and staff receive appropriate training and adequate supplies of personal protective equipment. There are effective procedures for all cleaning and laundering, and these are monitored regularly and frequently.

Outcome 2: Restraint Minimisation and Safe Practice

There are well developed policies and procedures which guide staff in the practice and safe use of restraints and enablers. There is a restraint committee which includes a general practitioner, senior nurses in the facility, a resident advocate and the restraint coordinator. Residents and family members are involved in decisions on the use of restraints and enablers, however there is an active focus on restraint minimisation.

When restraints are used there is assessment which includes consent, monitoring, evaluation and review of restraint use. The organisation carefully monitors its use of restraints and actively looks to reduce restraints wherever possible. Enablers are voluntary. Staff interviews and file reviews confirm the stated philosophy of restraint minimisation.

Outcome 3: Infection Prevention and Control

The service is able to demonstrate it provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control co-ordinator/Nurse Manager reporting directly to the general manager who reports to the board. There is a clearly defined infection prevention and control programme for which external advice and support is sought.

The infection control nurse/Nurse Manager and the infection control committee is responsible for this programme, including education and surveillance. Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. An initiative evidencing a reduction in infections and subsequent anti-microbial usage provides evidence of continuous improvement. Surveillance results are reported through all levels of the organisation, including governance.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	50	0	0	0	0	0
Criteria	6	95	0	0	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 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.	CI	A quality initiative to survey residents six weeks after admission ensures deficits in information and knowledge are addressed early to enable residents and family to be fully informed and actively involved with their care.
HDS(C)S.2008	Criterion 1.2.3.7	A process to measure achievement against the quality and risk management plan is implemented.	CI	There is regular review and evaluation of the organisation's progress against its strategic plan and quality goals, through the GM's annual reports to the Trust Board. Evidence of this evaluation is available through review of records and interview with the GM.
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	CI	The facility has improved the skills, knowledge and experience of a group of 18 staff members in the provision of end of life care and support to residents at Parkwood. There is evidence from family members, including letters of

Code	Name	Description	Attainment	Finding
		and effective services to consumers.		appreciation, staff members through their annual appraisals, formal evaluations of learning, and analysis of decreased transfers to hospice or hospital from the facility indicating that this has improved resident care/outcomes.
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	Parkwood Lodge provides an expansive range of activities both in and out of the facility that are resident driven. Pre planning of events occurs to identify and manage any identified risks. A review occurs post event, with analysis and evaluation of consumer satisfaction, and reporting of findings documented for referral in the future.
HDS(C)S.2008	Criterion 1.3.13.2	Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	A quality initiative to promptly detect and respond to residents dissatisfaction with meals has resulted in improved satisfaction with meals.
HDS(IPC)S.2008	Criterion 3.5.7	Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	Implementation of a quality initiative regarding the accurate diagnosis and classification of infections has resulted in a decrease of infections and decrease in antimicrobial usage.

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Parkwood Lodge is observed to provide an environment in which residents receive services in accordance with human rights legislation. Management (eight of eight) and staff (14 of 14) are familiar with the Code of Health and Disability Services Consumers' Rights (the Code) as evidenced during conversation with them and in sighted policy documents. Staff receive education on the Health and Disability Commissioner's Code (the Code) at orientation and through in-service training as sighted in staff records (12 of 12 employment, orientation and training records) and planned education programmes, and verified by interviews with staff.

Residents (two of two hospital residents, three of three rest home residents) and family/whanau (five of five hospital resident family/whanau) interviews verify the service complies with consumer rights legislation. Clinical staff (seven of seven) are observed to explain procedures being undertaken, seek verbal acknowledgement for a procedure to proceed prior to it being commenced, protect residents' privacy (eg, notes being locked away, confidentiality of information, privacy to make phone calls, staff knocking on residents' doors prior to entering their rooms), and address residents by a preferred name. Compliance with the Code is monitored through resident and relative satisfaction surveys. The ARRC requirements are met

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:

Parkwood Lodge provides an environment in which residents are informed of their rights. Residents are made aware of the Code and the Nationwide Health and Disability Advocacy Service with information brochures clearly displayed and accessible to all residents (sighted). Residents receive information on the Code and accessing the Nationwide Health and Disability Advocacy Service on admission, with opportunities for discussion, clarification and explanation available at admission and any other time as necessary. Information is also provided on access to support services and the facility's range of services provided. Legal advice is able to be sought on the admission agreement or on any aspect of the service at any time.

Advice to accessing interpreters is available should assistance be required to provide the information in a language and format that is suitable to the resident. The residents have access to the local health and disability service advocate if needed. As verified by staff, residents and family interviews. The ARRC requirements are met.

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:

Parkwood Lodge provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence. All hospital rooms occupied on the day of audit are single occupancy with ensuites. All suites occupied are either single or double (occupied by a couple) and have a small kitchenette and an ensuite. Bedrooms are of a size that allows appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their rooms or residents have their own phones. There are locks on communal toilet doors. Staff always knock on Residents' door prior to entering. The nurses' stations provide privacy of stored information. Privacy when discussion concerning residents takes place is in residents' rooms. Staff education on privacy takes place at orientation and during in-service education.

Residents receive services that are responsive to their needs values and beliefs. Care plans identify residents like and dislikes and interventions identify the assistance the resident requires to meet residents' needs, while being encouraged to be as active as possible. Residents are addressed in a respectful manner and by their preferred names, are assisted to maintain dignity and respect and to ensure sexuality, spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.

Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The individual employment agreement, house rules and job description directs staff to company policies and procedures and identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Awareness of these policies and procedures is verified and signed off at orientation. There are no concerns expressed related to abuse or neglect. All comments are positive.

Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives. Staff demonstrate an awareness of the need

to provide a service that is responsive to these needs. Evidence of this is observed, sighted in resident and staff files reviewed and verified in resident, family and staff interviews. The ARRC requirements are met.

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: 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 1.1.3.7 (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:

Parkwood Lodge recognises the special relationship between iwi and the Crown and appreciates that the principles of the Treaty of Waitangi (Partnership, Participation and Protection). The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing. There is a Maori health plan (sighted) that verifies consultation and input by the local marae in preparation of the plan and includes policies and procedures for all stages of service provision. The organisation's model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. There are no residents currently at Parkwood who identify as Maori. Staff receive education in relation to cultural safety and the Treaty of Waitangi. The requirements of the ARRC are met.

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:

Parkwood Lodge provides an environment that enables residents to receive culturally safe services which recognise and respect individual ethnic, cultural and spiritual values and beliefs. Included in the admission and ongoing assessment process, residents and/or family/whanau are consulted about individual values and beliefs. Any special cultural, spiritual, values and beliefs requirements needed to be met by the service are identified and documented to inform the care planning and activity planning process to ensure that resident's specific needs and objectives are met. Clergy of all denominations visit regularly, a multi-denominational roster of church service is sighted in the activities programme. Other requests can be arranged with management and some residents' families access their own spiritual support from the community. Open visiting policy allows family/whanau to visit when they are able. Staff receive in-service training on cultural safety and the Treaty. Evidence to support findings is sighted in resident file reviews and staff training records. Resident and family/whanau interviews confirm staff implement cares to meet their needs. The ARRC requirements are met.

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:

Parkwood Lodge provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service. Orientation/induction processes inform staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct, and informs staff about working within their professional boundaries. A signature acknowledging the terms related to all this information is located in all employment agreements. The Nurse Manager will action formal disciplinary procedure if there is an employee breach of conduct. Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. As evidenced in staff files and verified in staff, resident and family interviews. The ARRC requirements are met.

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:

Parkwood Lodge provides an environment that encourages good practice. All policies sighted are up to date, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. They are reflective of evidence based rationales which are monitored and evaluated at organisational and facility level.

Human resources are managed to employ competent employees. New employees complete a comprehensive orientation/induction programme that is relevant to the role being undertaken. Staff records evidence competent employment practices, orientation and training records. The service supports and encourages staff with appropriate on-going education relevant to the role they undertake. The service has an extensive and diverse in-service education programme in place which is monitored at organisational level to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. Staff interviewed confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner. Incident reporting systems are evidenced to be linked to open disclosure and quality improvement processes. All care staff have or are undertaking the Aged Care Education programme. Registered Nurses (RN's) and care staff who administer and/or check medication have yearly assessments to determine competency (sighted). All RN's plus care staff who work afternoon or night shift have up to date first aid certificates (sighted). Ongoing education for all staff is supported by the facility, Capital Coast District Health Board (CCDHB), the specialist services that they operate and the local Hospice services. Kitchen staff have qualifications in safe food handling.

Residents and relatives interviewed verify satisfaction with the services provided and resident satisfaction surveys undertaken annually indicates a high level of satisfaction with the service. An interview with the GP, verifies satisfaction with the services provided. The service responds promptly and correctly to requests and is prompt in requesting input if needed. The ARRC requirements are met.

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:

Parkwood Lodge provides an environment conducive to effective communication. Communication with relatives is documented in the communication sheet which is kept in the resident's file (sighted). Incident and accident forms evidence resident and/or family are informed of incidents, when requested. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme (records sighted). Staff confirm they understand that relatives and residents must be informed by the RN of any changes in care provision.

There are no residents that require interpreting services, however management staff are aware of how to access interpreters if this service should be required. S

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed). Residents and family interviews confirm communication with staff is open and effective, that they are always consulted and informed of any untoward event or change in care provision, and are included in care reviews as sighted in files reviewed (four of four hospital and five of five rest home), and interviews (five of five resident and five of five family/whanau), and sighted during audit. The ARRC requirements are met.

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:

Parkwood Lodge provides residents, and where appropriate their family/whanau, with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a welcome folder informing residents and families of the services provided. Residents are able to choose their GP of choice. The RN discusses information on informed consent with the resident and family/whanau on admission. Consents request the resident's agreement to; collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organised. Informed consent is evident in observation of activities at audit, with residents being actively involved in the decision making process.

In 2012 following an analysis of the resident satisfaction survey, it was decided to implement a six weekly post admission survey to assess residents' dissatisfactions/knowledge deficits related to being given too much information during the admission process, often at a time when residents are in distress. The survey captures all aspects of Parkwood Lodge's services. Surveys are sighted and evidence areas in which residents have concerns, are unfamiliar or feel uninformed. Follow-up action of those concerns and evidence of prompt attention is sighted. Evaluation of the effectiveness of this initiative is evidenced in improved results of the 2013 satisfaction survey and verified by resident and family interviews. This initiative is recognised as an area of continuous improvement.

Files reviewed evidence informed consent forms signed on admission and identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. Medicine charts have residents' photographs for identification. Residents' choices and decisions are recorded and acted on. An advance directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advance directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non consent to be revoked at any time. Advance directives are sighted in files reviewed.

Verbal consent is obtained prior to an intervention being carried out as observed and verified in clinical staff, residents and family interviews. Care plans are signed by the resident and/or family/whanau, where appropriate, to say they have read and agree with what is written.

Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process and confirm their understanding of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. The environment is observed to be one where choices are offered and openly acknowledged. Resident and family interviews confirm they are provided with the necessary information to make informed choices, choices are respected by staff and staff confirm they respect the resident's right to refuse to consent at any time. The consumer satisfaction survey results (sighted), indicate a high level of family/whanau satisfaction with involvement in care. The ARRC requirements are met.

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: CI

Evidence:

In 2012 following an analysis of the resident satisfaction survey, it was decided to implement a six weekly post admission survey to assess residents' dissatisfactions/knowledge deficits related to being given too much information during the admission process, often at a time when residents are in distress. The survey captures all aspects of Parkwood Lodge's services. Surveys are sighted and evidence areas in which residents have concerns, are unfamiliar or feel uninformed. Follow-up action of those concerns and evidence of prompt attention is sighted. Evaluation of the effectiveness of this initiative is evidenced in improved results of the 2013 satisfaction survey and verified by resident and family interviews.

Finding:

A quality initiative to survey residents six weeks after admission ensures deficits in information and knowledge are addressed early to enable residents and family to be fully informed and actively involved with their care.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Parkwood Lodge recognises and facilitates the right of residents to advocacy/support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the local Health and Disability Service Advocate or the Health and Disability Commissioner's office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format all around the facility and is included in the admission information.

The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons, as verified in clinical staff, residents and family interviews. The ARRC requirements are met.

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:

Parkwood Lodge provides an environment whereby residents are able to maintain links with family/whānau and their community. Residents are assisted and encouraged to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations. The service acknowledges, values and encourages the involvement of families/whānau in the provision of care and the activities programme actively supports community involvement and accesses community resources. Resident and family interviews confirm that visitors can visit freely and there is free access to community services. It is observed that there were visitors and village residents coming and going from the facility during the audit. File reviews, Nurse Manager, RN, diversional therapist, staff and the recreational officer confirm community services used by the facility include local social groups and local venues, the local community centre and village activities, local church groups and services, the CCDHB nurse practitioner and gerontology specialist and the local needs assessment and service coordination agency (NASC). The service has a podiatrist and physiotherapist who visits regularly, residents have the GP of their choice and CCDHB outpatient and inpatient services are accessed as appropriate. The ARRC requirements are met

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 quality manager nursing (QMN) (see also standard 1.2.3) who is responsible for handling complaints. Complaints may be reported to any staff member verbally or in writing in any format.

The QMN receives complaints in whatever format they arrive and records these on the register. The facility's complaint form (if it has not been used to write the complaint) is used to summarise the complaint and record the date it is received, the date of the acknowledgement (within five days of the complaint being made), and the date of resolution, within ten days after this.

The register is reviewed with the two quality managers, the QMN and the quality manager – administration (QMA). The register is up to date and records 14 complaints received so far in 2014. The complaints are acknowledged within five days of receipt and all have been resolved within the next 10 days, if they have not already been resolved. Complaints are responded to appropriately and there is respectful communication with complainants and family members. Both quality managers describe a clear link between the complaint process and the organisation's quality and risk management system.

A range of staff (14) and managers (eight) are interviewed. All confirm that they receive education about the complaints process. They accurately describe the process and assisting family to make a complaint. They report that complaints are seen as valuable feedback on how the organisation can improve and they are welcomed. Review of personnel files (12) confirm that staff receive training at orientation and through the biennial training programme in the complaints process and the Code of Rights. At interview with five residents and five family members all confirm that they know about the complaints process.

In 2013 the organisation introduced the six week post admission survey. This includes checking that the resident and their family knows about essential components of service delivery and the organisation's systems, including the complaints process. Review of the records shows that one resident's family were not aware of the complaints process and the post admission survey enabled the organisation to inform the resident and family about the process and ensure they know how to use it.

ARC contract requirements are met.

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:

The Parkwood general manager (GM) is interviewed during the audit. He reviews the strategic plan at the end of each calendar year and presents this to the Parkwood board at the beginning of the next year. His review occurs by considering the goals and purpose of the charitable trust, the political and financial environment and any relevant other factors which have occurred through the year. The board approves the plan, which includes the budget and financial plan, after discussion with the GM.

The GM reports that the goals of the organisation have not changed but have been consistent since it was opened in the early 1970s. This, and the annual review of the strategic plan, has allowed the organisation to remain focused and to achieve its goals, while still being able to respond to the changing business, health and contracting environment.

Parkwood is managed by the GM, a nurse manager and a clinical manager. The GM has worked at Parkwood for more than 20 years, and the clinical manager (CM) and nurse manager (NM) who are both registered nurses (RNs) have both worked at Parkwood for more than 10 years (the CM 28 years and NM 13 years). A review of their personnel files and from interviews demonstrates that they have the necessary skills, knowledge and experience to undertake their roles competently.

ARC contract requirements are met.

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:

Parkwood Lodge aged care facility is co-located with a large retirement village in Waikanae. The GM is responsible for the operation of the entire complex which encompasses the maintenance, selling, operation and functioning of the retirement village as well as oversight of the day to day operations of the aged care facility. While he visits the Lodge daily he is not involved in the day to day management of the aged care facility, this is the responsibility of the NM and CM. In a temporary absence of the GM, his financial and other responsibilities are delegated to a board member, usually the chairperson.

The CM works four days a week and the NM five days a week. There are also three nursing team leaders in the facility. The CM and NM can cover for one another in a temporary absence and the nursing team leaders can provide any additional support or tasks which may be required.

ARC contract requirements are met.

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:

The organisation's strategic plan outlines seven strategic goals which guide the work of the board, the senior management team and the quality and risk management system. These goals include: being the preferred choice of retirement village and providing a superior living environment; improving resident satisfaction levels; increasing the public profile; retaining skilled staff; improving efficiencies. Each goal has critical success factors and strategies to achieve the goal. It is the strategies, and critical success factors which change overtime, as well as the progress that is recorded against each goal. These goals guide the quality activities of the organisation.

There is a quality plan and quality workplan which outlines the wide range of quality activities which occur throughout the year. These include regular meetings; staff development; internal audits; workplace safety; infection control; restraint minimisation and document review. Prior to the introduction of certification to the Health and Disability Services Standards, the organisation held certification to ISO quality management standards. The structure of these standards is still evident in the quality management system, in particular. An area of continuous improvement is identified in relation to the organisation's practices in relation to its review of progress against its quality and risk management goals and its internal monitoring and audit processes.

There are two quality managers; a quality manager nursing who is an enrolled nurse and a team leader in the aged care facility, and a quality manager – administration (QMA). Both are interviewed throughout the audit. The QMA maintains the document management system and the register of all documents. There is a biennial review of all documents except for the infection control manual and the strategic plan, which are reviewed annually. Documents may be reviewed more frequently from time to time if needed. Different staff members will be involved in the review of a policy, procedure, and form depending on the topic if it is relevant to their field of expertise. All documents provided prior to the onsite audit, and reviewed during the audit are current and have been reviewed within the time frame required. Documents include footers which have the date when it was created, when it was last reviewed and it is signed by the approver and their name is recorded. Limited hard copies of documents are available in the

facility and these are in central locations and those that are needed in that area: the kitchen has the kitchen policy and procedure manual, each nurses' station has the nursing policies and procedures, the infection prevention and control and the restraint minimisation policies and procedures.

There are regular meetings of different teams across the organisation including the quality management review. This is a meeting of the GM, quality managers, NM, CM, team leaders of the hospital wing (one) the other half of the rest home, the kitchen, the domestic staff, and the maintenance team and it occurs monthly. At each meeting all aspects of the quality and risk management system are reviewed by the whole team. This includes reviewing event data, incidents, accidents, infections, medication errors, restraint and enablers use, health and safety events, complaints, compliments and any other relevant feedback or issues which have been identified. There is discussion of the types of events, frequency of each type and management strategies which have been used to respond to the event. There are three quality improvement meetings a year which include a resident representative. These meetings include a summary of events which have occurred and any significant activities undertaken in response to them.

The GM holds a two monthly staff meeting with all staff members. During this meeting, and made available to staff through their own functional team meetings, are graphs of event data by month, going back for four years. This allows for a comparison of data over time. At interview with 14 staff and eight managers confirms that they receive information and data about events both individual events they report, and about collated event data. All confirm that they receive timely information and sufficient to enable them to understand the most common types of events which are occurring at any time.

The organisation has a corrective action log in which are recorded the outcomes of internal audits to be implemented, or trends identified through event data analysis. The log is monitored by the quality managers and the quality management review meetings. It is current and includes the date of actions taken and implementation of actions.

There is a well described risk management plan which includes business, financial and relevant risks which could impact on the facility and its ability to deliver services to the high standard it has set for itself. The plan is reviewed in full annually, and the strategies to manage each risk are evident in the range of a quality monitoring, management and day to day activities observed and reported at interview during this audit.

A range of records are reviewed during the onsite audit. This includes quality management review minutes for each month for all of 2014 to the month of the audit (January – September 2014), the quality improvement meeting minutes (March and July 2014), the corrective action log, graphs of event data up to July 2014 (last meeting of GM with all staff members), the quality plan 2014, the strategic plan 2014 – 2019, the quality improvement review for 2013, the complaints register 2014 and 2013, the Parkwood quality manual.

Throughout the audit a range of staff and managers are interviewed (22). At different times quality systems and quality management is referred to and people talk about the ways in the organisation seeks feedback about its own performance and the importance of this. In discussing whether staff know about complaints, they state how important complaints are in this regard. Staff also mention the range of internal audits which are completed. All staff interviewed know about them, even if they do not complete them themselves. There are also informal ways in which the facility gathers feedback, for example, in the dining room there is a book in which residents are invited to comment on each meal. They can write whatever they like and leave their name or not. The kitchen team leader reads this daily. These comments are discussed at the kitchen team meetings and at the quality management review team meetings are noted in the minutes of these meetings when reviewed.

ARC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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: CI

Evidence:

Parkwood's quality goals are incorporated with the strategic plan and the strategic goals. The goals have remained consistent since Parkwood's development in the early 1970's but the critical success factors and strategies to achieve the goals are reviewed annually by the GM and updated for the coming year. The board of Parkwood Charitable Trust will approve the strategic plan before it is implemented. The strategic plan for 2014 – 2019 reflects the evaluation and review of the goals for 2013, the achievements in 2013 and the focus for 2014 and beyond.

Alongside this the review of the strategic plan, the quality management review team has reviewed their achievements at the end of 2013 and where they could have improved their performance. They have identified specific areas of focus for that group to work on in 2014 which align with the strategic goals and critical success factors, and aligns with the 2013 resident and family satisfaction survey results and the minor areas for improvement identified in that.

The residents' meeting (monthly) and feedback given to the GM through these meetings also informs the annual evaluation of goals.

Finding:

There is regular review and evaluation of the organisation's progress against its strategic plan and quality goals, through the GM's annual reports to the Trust Board. Evidence of this evaluation is available through review of records and interview with the GM.

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 Parkwood quality manual includes the designated responsibilities policy. This clearly describes the essential notifications to the coroner, police, district health board, Ministry of Health, internal communications (ie, Chairman of the Board of the Trust) and public health notifications. These notifications are clearly understood by the GM and QMA when discussed at interview during the audit.

There are several different event reporting forms including the incident/accident report, the complaint form, and infections. Different types of event reporting forms are reviewed the QMA and QMN

. Each event report is completed by the reporter, includes the follow-up action in response to the event, and any further action (ie, complaint resolution, open disclosure to family members). The individual event and follow-up action is recorded on a resident's file, if it is related to a resident, or a staff member's personnel file, or both.

Event data is collated by the QMA and QMN and discussed at the quality review management meeting (monthly), the quality improvement meeting, the team leaders' meeting, the management/staff meeting, the RN/EN meeting, the caregivers' meeting and the GM's two monthly meeting with all staff. Fourteen (14) staff members and eight managers are interviewed and all report that they are able to report any type of event which occurs in the facility. Staff are supported to report events so that the organisation can learn from them and make improvements. They receive collated data at the range of meetings they attend (as noted previously in the standard and 1.2.3). All agree that information about both individual events and collated event data is timely and enables them to take appropriate action to minimise risk.

ARC contract requirements are met.

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.

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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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Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

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

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

Attainment and Risk: FA

Evidence:

Those staff members who hold qualifications which are relevant to their position have these validated at recruitment. For employees who hold a professional registration and or annual practising certificate this is monitored by a member of the administration team and once the new annual certificate is obtained it is placed on the person's personnel file. Twelve (12) personnel files are sampled and of these six are nursing staff members. All six have a current annual practising certificate. The administration staff member also maintains records of the registration / practising certificates for the physiotherapist, podiatrist and two general practitioners who visit and provide services to the residents of the facility. These four health and allied health professionals all have a current practising certificate.

The NM is primarily responsible for all recruitment at the facility. The GM assists and has an oversight role in recruitment and selection, but the NM has the authority to manage all appointments. The team leaders of each area undertake the interviewing and selection of staff members in their own teams, with involvement of the NM on the interview panel. Sampling of personnel files (12) includes two staff members who have been appointed since the NM has held her current position. Both these files confirm that the NM has followed the organisation's current recruitment, selection and appointment processes, as those of the other 10 employees confirm that the process followed at the time of their appointment (in some cases more than 20 years ago) was followed. Staff employed within the last 10 years have evidence of police checks, reference checks and the associated practices of good employers which are considered to be usual practice in human resources management systems in the health sector.

Parkwood's induction and orientation system is well evidenced on employee files, and employees interviewed 22 (14 staff and eight managers) are able to describe their orientation. The current induction includes the components of employment legislation: an employment agreement, taxation, leave provisions, confidentiality, privacy, the house rules; and the orientation incorporates a period of 'shadow shifts' of between five to eight days depending on the person's previous experience and then specific learning areas which are accompanied by learning and competency assessments. These include, but are not limited to the following areas: residents' rights - the Code of Rights, informed consent, communication, abuse and neglect; restraint minimisation – the restraint and enabler policy, challenging behaviours and a restraint knowledge assessment; a building orientation - the emergency response procedures, the evacuation plan, fire fighting equipment, where to find it and how to use it, hazards; event reporting and quality management systems; manual handling; basic infection control - standard precautions and use of personal protective equipment; and Parkwood's history and beginnings as one of the earliest retirement villages and aged care facilities with a model of license-to-occupy units with the provision of rest home level care.

Ongoing training is provided under a comprehensive biennial training programme. This incorporates a training calendar of training sessions delivered internally at Parkwood by some external presenters and some Parkwood staff members. There are also in-service training sessions which are delivered at staff meetings, shift hand-overs and other opportunities for providing specific training and information to staff as and when needed on specific topics. In-service training often occurs after the updating of policies and procedures. Alongside these training options there is ongoing professional development undertaken by a number of staff. Currently there are 48 caregivers at Parkwood. Of these, there is one caregiver who is an enrolled nurse and four who are nursing students. Of the remaining 43 caregivers, 28 already hold an ACE (Aged Care Education) qualification; this is either one or more of the ACE core competencies certificate, the ACE dementia certificate and the ACE advanced certificate. Of the remaining 15 caregivers there are three new staff who are still completing their orientation, and of the remaining 12 there are seven caregivers who are currently completing study on one of the ACE certificates.

A group of 18 nurses registered nurses (RN)s and enrolled nurses (ENs) and caregivers are completing the Hospice New Zealand "Fundamentals of Palliative Care" programme. This encompasses nine modules and commenced with the first module in November 2012 and will be completed with one final module in November 2014. An area of continuous improvement is identified in relation to this programme.

ARC contract requirements are met.

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.

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p>

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: CI

Evidence:

In 2012 Parkwood identified the need to improve their delivery of end of life care and support to residents. A group of 18 RNs, ENs and experienced caregivers are completing the Hospice New Zealand Fundamentals of Palliative Care programme.

A review of annual performance appraisal documents over 2013 and 2014 from this group of staff demonstrates their increased proficiency and confidence in supporting residents at the end of life stage. Course evaluations similarly demonstrate positive learning outcomes and transfer of learning. A post learning survey has also been completed by the NM to monitor the transfer of learning.

A selection of letters from family members is reviewed with the NM and GM. They include families who talk about the importance of their loved one remaining in what has been their home, with family around them. Families also mention the range of options available to support their family which included liaising with the Hospice team and having 'difficult conversations' to assist the whole family.

Finding:

The facility has improved the skills, knowledge and experience of a group of 18 staff members in the provision of end of life care and support to residents at Parkwood. There is evidence from family members, including letters of appreciation, staff members through their annual appraisals, formal evaluations of learning, and analysis of decreased transfers to hospice or hospital from the facility indicating that this has improved resident care/outcomes.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Managing Resources policy notes that the senior staff meet weekly to discuss long and short term resource requirements. There are monthly meetings of the Trust board and the residents' committee. One of the items on the regular agenda of these meetings is resources and any the plans, rosters, staffing levels and budget can be updated as and when necessary to accommodate changing needs or increases / decreases in occurrences of events.

The managing resources policy clearly sets out the staffing numbers across the facility on each shift. There is a detailed rationale for the rostering of each area of the facility and each shift. In the hospital wing:

- on each morning shift there is an RN on duty 7am – 3.30pm, 1 caregiver on 7am – 10am, 3 caregivers 7am – 1pm, and 2 on from 7am – 3.30pm.
- on each afternoon shift there is an RN on duty 2.30pm – 11pm, 2 caregivers on 2.30pm – 11pm, 1 caregiver on 4pm to 8pm, and 1 on 4pm to 9pm.
- on the night shift there are an RN 10.45pm – 7.15am and 3 EN or caregivers 10.45pm – 7.15am

The rest home is divided into two areas and each has a team leader. In Rest home one – the team leader is an EN (and is the QMN) and Rest home two – the team is an RN.

Rest home one and two are also each divided into two blocks, so there are four blocks across the whole rest home. In each block the staffing levels are:

- on each morning shift a caregiver or EN is on duty on each block 7am – 3.30pm and there is a floater caregiver / EN who works across two blocks for the same time
- an extra caregiver/EN is added to the rest home area to cover the dual purpose beds depending on whether there are five, ten or fifteen dual purpose beds being used as hospital level care
- On the afternoon shift there is 1 RN or EN for both Rest home one and two from 4pm to 9.30pm, and four caregivers (one on each block) from 2.30pm to 11pm
- On the night shift there are three EN/caregivers on duty across the rest home from 10.45pm to 7.15am who can the RN in the hospital wing if needed
- During the evening and night shift the CM or a relieving RN is available on call for advice
- An additional caregiver can also be added to the roster if there 15 dual purpose beds occupied in the rest home or if there is a resident receiving complex palliative care

At interview with a range of staff members (14) and managers (eight) they are questioned on their view of staffing levels and the organisation's ability to respond to the changes in needs of residents with the dual purpose beds. All staff interviewed (22) report that staffing levels are safe and that on the rare occasion they are not fully staffed due to sickness then "...everyone pulls together and helps out so that no residents miss out on the care they need."

Several family members interviewed during the audit, comment on the positive team environment and how well staff work together. They state that staff are always happy, welcoming and do their best. The 2013 resident satisfaction survey results have a 96% satisfied or very satisfied response rate for 'assistance'. Overall there was a 57% response rate to this survey. All residents, or family on their behalf, were surveyed.

ARC contract requirements are met.

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:

Residents admitted to Parkwood Lodge have the information relevant to their circumstances recorded on the day of admission and always within 24 hours of admission (five of five rest home and four of four hospital residents' files are reviewed). The residents' records contain information to safely identify the resident, it is legible and dated.

Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded.

All records sighted are secure. Residents' current files are stored in a key pad locked office. Archived files are in a locked easily accessible room. Resident information is kept in hard copy format. The registered nurse deals with resident's file content. The service is not responsible for NHI numbers. The service receives referral information from Care Co-ordination (local NASC) which includes relevant assessment and medical information. This information is used to develop individual client files. The administrator keeps a computerised register of past and present residents which includes details of name, NHI, DOB, GP, admission date and address, NOK and date left service (including discharge address) and or deceased. This is then saved and archived when a new resident is admitted to ensure the register is always up to date. All relevant ARRC requirements are met.

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: Parkwood Lodge provides an environment whereby when the need for service has been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. Service availability, information, access and entry criteria are documented and communicated to residents and their family/whanau by the facility's website, local

doctors, referral agencies, Capital Coast District Health Board (CCDHB), the Eldernet website, village residents and local community groups. Information includes full details of the services provided, its location, hours, how the service is accessed and identifies the process if a resident requires a change in the care provided. Prior to entry, the resident must be assessed by the Care Co-ordination Centre Needs Assessment and Service Co-ordination (NASC) agency in the area to ensure they require the care provided. If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the local NASC agency. All enquiries are documented on a facility enquiry form. Information is sent out or given to prospective residents. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Nurse Manager or RN. Nine of nine files reviewed contain completed assessments by the Care Co-ordination Centre verifying placement is required. Admission agreements are signed and sighted in each of the files (four of four hospital and five of five rest home) reviewed. Admission agreements meet contractual requirements. Resident and family members interviewed confirm they were informed and involved in this process. The ARRC contract requirements are met

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:

Parkwood Lodge has a clear process for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential service. The reason for declining entry are documented and kept on file.

The admission agreement, describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility. The ARRC contract requirements are met.

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: FA

Evidence:

Each stage of the service provision is undertaken by a suitably qualified provider and is developed with the resident and their family/whānau. Within 24 hours of admission the initial assessment process is undertaken by the registered nurse (RN) and includes gathering data from the resident, their family/nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the residents' immediate needs. A medical assessment is conducted by the resident's general practitioner (GP) within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks. Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data. The long term care plan directs the care required to meet the residents need and desired outcome.

Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift. The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents' needs change. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents' desired outcomes are being

met. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The residents medication charts (eight of eight hospital and 10 of 10 rest home) sighted are reviewed three monthly or as needs change and this is conducted by the GP.

A gerontologist and nurse practitioner visit every six weeks and review any residents of concern and those requiring specialist input. Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the resident's care. Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. Sixteen (16) of 16 clinical staff (and two care givers) have attended eight of nine Palliative Care training modules through the hospice, with one yet to be completed (Refer 1.2.7.5). The cooks and kitchen assistants have qualifications in food safety training. The contracted physiotherapist and podiatrist provide services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

Each RN oversees the residents whose care they are responsible for planning. Residents are attended to by their GP of choice. A verbal handover by the RN occurs at the beginning of each shift to ensure all staff is familiar with the resident needs. Health professionals are allocated the residents they are to deliver care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in resident's files, where specialist input is required. Family contact is documented in the family contact record. Evidence of this is sighted in files reviewed (four of four hospital, five of five rest home, 12 of 12 staff) and verified by interview (three of three rest home residents, two of two hospital residents and five of five hospital residents family/whanau). Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews. The ARRC contract requirements are met.

Tracer methodology one - A hospital resident is reviewed using tracer methodology.

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

Tracer methodology two - A rest home resident is reviewed using tracer methodology.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.4: 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:

Within 24 hours of admission residents' have their needs identified through a variety of information sources that includes the NASC assessment, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom or suite with the resident and/or family/whanau present if requested.

Over the next three weeks, the RN undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care and activity planning. The assessments are reviewed six monthly as needs, outcomes and goals of the resident change.

A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. Evidence of this is sighted in files reviewed.

Resident and family interviews, verify they are included and informed of all assessment updates and changes. Staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs. The ARRC requirements are met.

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:

The care plan developed in consultation with the resident and/or family/whanau, documents the residents' individual plan of care identified by initial and on-going individual assessments, and describes the required support to enable the resident to meet their needs, goals and desired outcome. Residents have one set of clinical notes in which all providers involved with the residents care use to document the resident's progress.

Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, diversional therapist, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers.

Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, handover sheet and the resident's care plan. Care plans are evaluated six monthly or more frequent as the resident's condition dictates. Short term care plans, document the existence of short term problems and the required intervention.

Information from the assessment process informs the allied services of resident need. The kitchen is informed of need regarding nutrition, activity assessments inform the activities officer and diversional therapist of interventions required in the activities programme, the physiotherapist is informed of any need for physiotherapy input and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need. Evidence of this is sighted in files reviewed. Resident and family interviews, verify they are included in the planning of their care. Timely access to other health providers is evident in residents' files, where specialist input is required.

The staff education records sighted for 12 of 12 staff demonstrate that staff receive extensive and appropriate training. The RNs participate in training and study days offered by CCDHB and specialist services. Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. The ARRC requirements are met.

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: FA

Evidence:

The care and services at Parkwood Lodge are delivered in a safe and respectful manner. The provision of care is consistent with the desired outcomes in residents' files reviewed which document the residents' physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.

Interviews with residents and family/whanau members expressed satisfaction with the care provided and verify new residents are welcomed and orientated to the facility.

There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident's needs (sighted). The ARRC requirements are met.

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

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

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

Attainment and Risk: FA

Evidence:

Parkwood Lodge has four personnel employed to provide residents with planned activities. One of these is a trained diversional therapist, diversional therapist educator and an assessor for the diversional therapy programme. On admission, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident's preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents.

The activities programme sighted (one hospital and one rest home) is planned in conjunction with residents' skills, likes, dislikes interests, discussion and request. Numerous requests for outings and activities are made and once the decision has been made on what activities or events are to occur the diversional therapist begins the planning process. Previous recent outings include ten pin bowling, numerous museum visits and a visit to Southwards Car Museum. Recent events include making Baileys Liqueur, Ginger Beer, snooker competitions and 'Love a Pet' day. Sighted planning sheets are reviewed, in which there is comprehensive assessment data recorded to identify factors addressed to make the event successful. Risks are identified as are the strategies to manage the risks. In the event of the diversional therapist being absent, a colleague is able to identify what is needed for the event to go ahead without her.

Following the event, the event is evaluated by all parties involved. The residents decide whether they were satisfied or not. Results of findings are integrated into the planning of the next event. Evidence of event planning and evaluations are sighted. This is an area identified as one of continuous improvement.

Individual activity assessments are updated or reviewed at least six monthly with a monthly summary of the residents response to the activities, level of interest and participation recorded. Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. The goals are developed with the resident and their family, where appropriate. A residents' meeting is held monthly, and meeting minutes evidence that the activities programme is discussed. The yearly resident/relative

satisfaction survey also captures feedback on the activities programme. Residents and family are highly satisfied with the activities offered. The diversional therapist and activities co-ordinator interviewed reports feedback is sought from residents during and after all activities. The ARRC requirements are met.

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:

A quality initiative is in place at Parkwood Lodge which is aimed at improving the activities programme to best match resident needs and desired outcomes. Sighted planning sheets are reviewed, in which there is comprehensive assessment data recorded to identify factors addressed to make the event successful. Risks are identified as are the strategies to manage the risks. Following the event, the event is evaluated by all parties involved. The residents decide whether they were satisfied or not. Results of findings are integrated into the planning of the next event. Evidence of event planning and evaluations are sighted.

Finding:

Parkwood Lodge provides an expansive range of activities both in and out of the facility that are resident driven. Pre planning of events occurs to identify and manage any identified risks. A review occurs post event, with analysis and evaluation of consumer satisfaction, and reporting of findings documented for referral in the future.

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:

Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if the RN decides that this is the appropriate course of action. Family/whanau are kept informed of changes. Formal care plan evaluations are conducted at least six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan. A short term care plan is initiated for short term concerns such as infections, wound care, changes in mobility and the resident's general condition. Evidence of evaluation is sighted in files reviewed. Resident and family interviews, verify they are included and informed of all care plan updates and changes. A multidisciplinary review is included in the six monthly evaluation, with all disciplines reviewing and evaluating the care provided to the residents. The ARRC requirements are met.

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:

Resident support for access or referral to other health and/or disability service providers is facilitated to meet the resident's need. If the need for other non urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services, and where possible a family member accompanies the resident. The facility has access to a van that can escort residents to appointments.

Residents are given a choice of GP when they are admitted. Most residents use the contracted GP who visits weekly.

A gerontologist and gerontology nurse practitioner visits the service every six weeks enabling specialist input for residents requiring it.

Acute/urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed. The ARRC requirements are met

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:

Exit, discharge or transfer is managed in a planned and co-ordinated manner that keeps the resident family/whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. There is a specific transfer/discharge form that records all the relative information needed when transferring a resident. If the resident is transferring to the CCDHB a descriptive process, detailing the specifics of what is to be included, is followed to enable a smooth transition for all parties involved. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes. The ARRC requirements are met

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: FA

Evidence:

The Medication Management Policy at Parkwood Lodge is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.

Medicines for residents are received from the pharmacy in the Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. All staff who administers medicines has current medication competencies (sighted). The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management.

Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed and administered, are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.

The medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed (18 of 18) have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.

There are a number of residents in the rest home (suites) who self-administer their medicines at the time of audit. The sighted assessments for self administration is in the files reviewed and meet the facilities policy. Medicines are stored as per policy.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed with appropriate action taken. The resident and/or the designated representative are advised. No incident of drug errors is evident in the nine of nine files reviewed. Sighted incident forms relating to drug errors verify appropriate action is taken.

The Nurse Manager or clinical manager monitors to ensure all staff who administer medications have current competencies. All RNs and healthcare workers who administer medication in the rest home are assessed for medication competency yearly (documentation sighted), under the direction and delegation of a RN.

Standing orders are used at Parkwood lodge. The written authorisation (sighted), signed by the resident's GP, identifies the directions and clear indications for each medicines use. The standing order specifies the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. The standing order authorisation is reviewed yearly. The ARRC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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:

The food, fluid and nutritional requirements of the residents at Parkwood Lodge are provided in line with recognised nutritional guidelines for older people as verified by the dietitians documented assessment of the planned menu, that changes seasonally (sighted).

Training records verify the cook and kitchen staff are trained in food and hygiene safety.

Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the resident's recommended nutritional requirements.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed.

A quality initiative was implemented around the area of meal satisfaction. On admission it was noted new residents were often too unwell or disinterested in completing a nutrition profile or a family member was completing it on their behalf. This resulted in inaccurate information being provided to the kitchen and residents being dissatisfied with meals (as evidenced in meal satisfaction surveys (2012 = 76% satisfaction)). In December 2012 an initiative was instigated to maximise residents enjoyment of meals to individual taste and requirements. The kitchen team leader now meets with the residents within one to three weeks of admission (as condition permits) to discuss how the resident is finding their meals, any extra likes, dislikes, meal sizes, food preferences and discussion around the dining experience. Any changes are followed through to the kitchen staff with the charge nurses and dietitian informed and input sought when necessary. An additional form operates alongside the nutritional profile, kept in the kitchen. Ongoing input of residents' satisfaction with meals is sought through ongoing visits to residents by the kitchen team leader, a communication book in the dining room (where feedback from residents via staff in regards to food is recorded and responded to), and feedback from residents' meetings. The 2013 survey results show an increase in the percentage of residents satisfied or highly satisfied with the food service (2013 = 91%). A review of residents' meeting minutes show there has been no complaints around food since October 2013. The communication book evidences positive comments on the food service. The results of the 2014 survey have not yet been collated however resident and family interviews verify extreme satisfaction with nutritional services.

The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs are sighted. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed (sighted and roster reviewed). The dining rooms are clean, warm, light and airy to enhance the eating experience.

Food is ordered by the cook. Fruit and vegetables are ordered daily depending on need and availability and meats and fish are ordered as required. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, chiller and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC requirements are met.

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: CI

Evidence:

There is a kitchen review process established to ensure prompt interventions and ongoing resident satisfaction with meals at Parkwood Lodge. In 2012 the annual resident satisfaction survey identified some dissatisfaction with the meals (76% satisfaction). After discussion with a number of residents and the management group, a decision was made in December 2012 to implement an initiative to maximise resident's enjoyment of meals. The 2013 survey results show an increase in the percentage of residents satisfied or highly satisfied with the food service (2013 = 91%). A review of resident meeting minutes show there has been no complaints around food since October 2013. The communication book evidences positive comments on the food service.

Finding:

A quality initiative to promptly detect and respond to resident's dissatisfaction with meals has resulted in improved satisfaction with meals.

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:

At interview with the domestic staff team leader and a group of seven caregivers, domestic and kitchen staff members, they report that they know the procedures for the management of waste and hazardous substances and that these are followed. They consider that the procedures are appropriate and that they are safe when handling such substances.

Observed during the on-site audit are the domestic staff using appropriate protective equipment (aprons and gloves) for the tasks they are undertaking. There are adequate supplies of protective equipment (to wear and for use in disposing of waste and hazardous substances) to meet the demands of their day-to-day job.

The cleaning team leader conducts a two monthly internal audit. This includes the procedures for management of waste and hazardous substances and use of personal protective equipment. The internal audits for 2014 and 2013 are reviewed with the team leader. These note consistent following of the organisations procedures by staff members.

ARC contract requirements are met.

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:

There is a current building warrant of fitness for the facility which was issued on 5 April 2014. There has been no reconfiguration or addition to the facility since the last onsite audit.

The maintenance team leader and a maintenance team member are interviewed during the onsite audit. They share responsibility for the physical environment and ensuring that all physical systems are operating (see also standard 1.4.7). The annual electrical safety testing is current and was completed most recently on 10 April 2014. Hot water monitoring occurs on a monthly schedule. Records are sighted and indicate regular checks occurring. Remedial action is taken if necessary and water is available in resident bathrooms at a safe temperature.

The environment has been purpose built and is designed to promote safe mobility and independence of residents. This is observed during the audit visit, as are the multiple accessible external areas which can be used by residents when weather permits.

At interview with five residents and five family members all comment on their satisfaction with the environment and the standard at which it is maintained.

ARC contract requirements are met.

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:

Throughout the facility in both the rest home and hospital areas, all rooms have their own bathroom and toilet. In the rest home areas these are apartments with a bathroom. In the hospital wing these are ensuite bathrooms with a toilet, wet area shower and vanity unit.

Privacy is assured as bathrooms are 'single use' by the individual or couple (some rest home apartments are doubles).

Staff and visitors' toilets are identified as such and there are sufficient numbers to meet demands.

ARC contract requirements are met.

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 are generously proportioned and beds can be maneuvered within the bedroom and around the facility if needed, with attendants.

During the onsite audit, residents are observed moving around the facility using mobility equipment including walking frames, manual wheelchairs and scooters. Corridors are wide and can easily accommodate walkers and residents using mobility equipment.

The five residents interviewed and five family members interviewed all state how much they enjoy and appreciate the environment at Parkwood, in particular the apartments for rest home residents and bedrooms for hospital residents. (The resident satisfaction survey does not include specific questions about the environment.)

ARC contract requirements are met.

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:

There is a large central dining room which is mainly used by rest home residents. This dining room can accommodate additional residents on special occasions, including hospital residents and / or some village residents.

In the hospital wing there is another dining room. This is of sufficient size that it can accommodate the larger chairs used by many hospital residents, as well as dining tables and staff serving and assisting with meals.

Placed around the facility are other rooms and spaces used for recreation and activities. There is a quiet room which is separate and has a door for privacy. There are two large lounge / sun room type areas which are used during the audit by different groups of residents for casual gatherings and organised events at different times (eg, the weekly religious service, a craft session run by the recreation coordinators, two women setting up and using a loom for weaving, a group of residents meeting for afternoon tea and a get together).

There are wide spacious corridors which include smaller areas of casual seating and tables for small groups / individuals to sit and read, knit, talk or enjoy a quiet moment on their own. All of which is observed to occur during the audit.

The five residents interviewed and five family members interviewed all state how much they enjoy and appreciate the environment at Parkwood. (The resident satisfaction survey does not include specific questions about the environment.)

ARC contract requirements are met.

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:

The domestic team leader is interviewed and describes her methods for monitoring the effectiveness for cleaning and laundry services. She has an allocated area she is responsible for cleaning, and works fulltime, five days a week. This gives her the opportunity to visually monitor the cleanliness of the facility, and the work of her team, on a daily basis.

On a fortnightly basis the team leader will randomly visit several rooms that other team members are cleaning. Every two months she conducts an internal audit of all the rooms against the organisation's cleaning standards and guidelines. The records of these internal audits are reviewed with the team leader and go back a number of years (immediately on hand are those back to 2009).

In the laundry a domestic staff member is interviewed and she describes a similar process of monitoring the effectiveness of the laundering process as it occurs. If clothes or linen is not effectively cleaned, it is (re)soaked, re-washed, or otherwise treated to cleaning it properly.

The facility uses Ecolab cleaning products and the Ecolab representative visits monthly and conducts their own monitoring of the effectiveness of cleaning and laundering. These records are also reviewed with the domestic team leader and demonstrate both effective cleaning and also issues which have been identified and adjustments made through to a replacement washing machine having been installed in early 2014.

In the 2013 resident satisfaction survey (the 2014 is not yet due to be completed), the satisfaction ratings were: Cleaning 98%, Laundry 95%.

ARC contract requirements are met.

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:

The maintenance team leader and a maintenance team member are interviewed for this part of the audit. They maintained all systems in relation to the building, the essential, emergency and security systems. The Parkwood orientation programme includes a building orientation. At a specific interview with seven staff about training they talk about this in particular. Any staff member who wants to can attend this programme when it is run so most staff attend it annually. The maintenance team leader delivers the session and it covers the evacuation plan and how to turn off the mains power, gas and water and how to turn on the emergency supplies of the same.

There is a 20,000 litre water storage tank on site and 100 litres of petrol which is used to run two generators on site. One of these generators is mobile and can be moved into the kitchen to run the light, refrigerators and freezers. There are six, nine kilogram gas cylinders which are used for the two large barbeques in the summer months, and these are available for emergency cooking.

There is an approved evacuation scheme, which was approved by the Fire Service department on 17 March 2006. Fire evacuation practices occur six monthly and these are witnessed by the contracted service representative. The local fire department will no longer attend fire evacuation practices unless specifically asked and the maintenance team leader reports that even then they are not willing to do so, whereas their Redfire contractor, who has appropriate skills and knowledge to assess an evacuation practice, is willing to attend and does so regularly.

There is sufficient food and water on site to provide meals and in a civil defence emergency. There are other supplies and equipment appropriate for a civil defence emergency in easily accessible storage.

All entrances are locked at night and unlocked in the morning by staff so that the facility is secure overnight. The 2013 resident satisfaction survey results show that 96% of residents who responded to the survey are either satisfied or very satisfied with their safety and security at Parkwood.

A call bell system is used in the facility. Each apartment (both rooms), bedroom and bathroom has a call bell and there are call bells in the communal areas. These are responded to promptly by staff and this is observed during the audit event. The 2013 resident satisfaction survey has a satisfaction rating of 98% to the Assistance question, which includes the call bell response.

ARC contract requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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 have large windows which overlook gardens and allow in natural light. Windows can be opened while having safety catches to ensure security. All rooms are light, airy and can be ventilated to the individual's preference.

The facility is a safe and comfortable temperature throughout the audit visit. Review of the range records seen during the audit confirms that there are adjustments to the heating to increase / decrease the temperature within the facility when needed to ensure that the environment is comfortable and safe for residents.

ARC contract requirements are met.

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Review of the restraint approval group records and two files for residents who currently use restraints (one) or enablers (one) confirms that enablers are used voluntarily and with the person's consent.

The restraint coordinator (an RN) and the QMN are interviewed in relation to restraint. Both consistently demonstrate their knowledge and understanding of these standards and the organisation's restraint minimisation and safe practice procedures.

ARC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

Parkwood's restraint approval processes clearly define the lines of accountability for approval, and monitoring of restraint use. As noted, the restraint coordinator, who has been in the role since June 2014, demonstrates a sound understanding of the organisation's whole system for the safe restraint practice.

The restraint committee is made up of the restraint coordinator, one of the two GPs, the CM, the hospital wing RN / team leader and the spiritual / advocacy / support representative. The group meets three monthly. The minutes of these meetings for 2014 are reviewed (March, June and September). These demonstrate that only approved restraints are in use and restraint use is only commenced when the approval and consent process is completed.

The restraints used at Parkwood are bedrails, tray tables, lap belts, and a safety vest which is used by one resident only and was implemented when they were at another facility and this resident's next of kin insists this is continued to be used. (The restraint coordinator and QMN report that while doing so, they are still exploring other options which would maintain the resident's safety but not restrict their movement.)

The review of the two residents' files and interview with the restraint coordinator and QMN confirms the meeting minutes.

ARC contract requirements are met.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint 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 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The restraint coordinator describes the restraint process. She emphasises the philosophy of restraint minimisation and that the assessment and consideration of restraint use includes the consideration and trial of all possible alternative before implementing a restraint. This is consistent with the restraint procedure document.

Review of the two files confirms that although one file is for a resident with an enabler device, both have had a assessment which has explored alternatives, included discussion with resident who is able to give consent themselves, as well as with family members, a full assessment has been completed on their file which includes all requirements of the Standard and is recorded on the individual's file.

ARC contract requirements are met.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

(a) Any risks related to the use of restraint;

- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

In both cases reviewed (two) the device used (one restraint and one enabler) are the least restrictive option. Additional records reviewed (restraint committee minutes, quality management review committee minutes, annual internal audit of restraints), confirm that the organisation's stated philosophy of restraint minimisation is implemented.

At interview with a range of 14 staff members they are asked whether there is ever any inappropriate restraint use. All describe only appropriate use, after full assessment which explores alternatives. Caregivers and domestic staff report that there is an environment where they can speak up if they think there is inappropriate restraint use but this does not occur. Review of incident / accident and other event reports similarly has no reports of inappropriate restraint use.

In a facility of 76 residents, with 34 of these residents hospital level on the days of audit, there are nine restraints in use at the September restraint committee meeting. Five bed rails, three lap belts and the one safety vest. The meeting minutes include references to restraints not being used because they are not needed and that they will be discontinued.

Restraint and enabler monitoring documentation is maintained by staff at appropriate intervals. There is an explicit restraint record which includes the type of restraint in use, by month, when they are commenced and / or discontinued and the reason, and the use of enablers.

ARC contract requirements are met.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint 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 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

Restraint use is evaluated one month after the restraint use is commenced and then at three monthly intervals in conjunction with the GP, the senior nursing staff and the resident's family. Evidence on the restraint evaluation is confirmed through review of files and interview with the restraint coordinator and the QMN. (Additional review of files by the clinical auditor also confirms that restraint evaluation occurs.) The restraint assessment form is used for the evaluation and includes all required areas defined in the Standard. Files reviewed includes the involvement of residents who are able to give consent themselves even where family members may hold EPOA and give formal consent on their behalf.

At interview with the restraint coordinator and QMN they describe the importance of the evaluation process and the continual focus on restraint minimisation.

ARC contract requirements are met.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

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 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The restraint committee has three monthly regular meetings to undertake its routine business. At six monthly intervals the committee meets to review restraint use and this most recently occurred in June 2014. The restraint coordinator reports on the restraint use and analysis of restraint minimisation activities. The focus on reducing the use of restraints wherever possible is evidence in these minutes and in the report given on this to the quality management review meeting.

The quality review of restraint use includes the provision of training to staff and the delivery education covering the organisation's policy and procedure on restraint minimisation and safe practice, challenging behaviours and de-escalation and positive behaviour strategies.

ARC contract requirements are met.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Parkwood Lodge provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. There is an infection control committee that includes a representative from each area and the infection control co-ordinator (who is the Nurse Manager). The infection control committee members implement the infection control programme as it relates to their area.

It is the responsibility of the Nurse Manager to ensure appropriate resources are available (sighted) for the effective delivery of the infection control programme.

The infection control practices are guided by the infection control manual and assistance from the CCDHB infection control nurse and microbiologist where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these is sighted at audit. Reporting lines are clearly defined, as verified in staff interviews. The infection control nurse (Nurse Manager) records monthly infection rate data, as evidenced in files reviewed and infection records, and present a monthly report to the quality management meeting and staff meetings (minutes sighted).

The infection control programme is reviewed annually.

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 Nurse Manager is responsible for infection control at Parkwood Lodge. A position description is included in the infection control (IC) programme and in the Nurse Manager's file.

The infection control nurse verifies there are enough human, physical and information resources to implement the infection control programme. She takes responsibility for implementing the infection control programme and has access to expert advice when required. Infection control training of the infection control nurse occurs via training offered through CCDHB.

The infection control nurse has access to diagnostic records to ensure timely treatment and resolution of infections.

The infection control nurse facilitates the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. Any IC concerns are reported to the infection control committee and the quality management meeting.

IC data is collected monthly and statistics and data is graphed and calculated.

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:

Parkwood Lodge has an infection control (IC) programme that is reviewed annually, and includes policies and procedures. These cover infection control surveillance, standard precautions, hand hygiene, safe management of sharps, collection of specimens, infectious spills, needle stick injuries, management of an outbreak, isolation precautions, disinfecting and sterilisation, antibiotic and antimicrobial, influenza, vaccination, wound care, risk management, building renovations, waste management and cleaning and laundry management. All are signed off by the manager as current.

Staff interviewed (seven of seven clinical staff) are able to describe the requirements of standard precautions and could say where the IC policies and procedures are for staff to consult. Cleaning, laundry and kitchen staff (three of three) are observed to be compliant with generalised infection control practices.

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 nurse has ongoing training in updated infection control practices and informs staff and GPs of all updates.

Staff receive orientation and ongoing education relevant to their practice as verified by staff training records and interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.

Resident education occurs in a manner that recognises and meets the resident's and the family's communication style, as verified by interview with residents and family/whanau.

There have been no outbreaks of Norovirus since 2011.

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:

In line with Parkwood Lodge's IC policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form and graphed. These are collated each month and analysed to identify any significant trends or possible causative factors.

Incidents of infections are graphed and presented to the infection control committee, the quality management meeting (monthly) and staff meeting. Any actions required are implemented.

A quality initiative is in place at Parkwood Lodge aimed at accurate diagnosis of infections and reducing the inappropriate or unnecessary use of antibiotics. An analysis of infections in 2013 evidenced possible inappropriate prescribing of antibiotics for urinary tract, soft tissue and mucosal infections, related to misdiagnosis of an infection in long term care facilities. Education was provided to RNs on 'definitions of infections in long term care facilities' revisiting McCreer Criterion (2012) to ensure clear criteria was met before an infection was classified. The infection control co-ordinator attended up to date education sessions through CCDHB on best practice for prescribing in aged care and shared this information with the GPs and RNs with the aim of optimising antimicrobial use in order to reduce antibiotic resistance. Antibiotics if needed were, where possible, only prescribed after sensitivities were identified. The microbiologist was contacted several times for advice. More localised treatments for wounds and the use of silver dressing was implemented. Graphs of infection data verify a reduction in urine and soft tissue infections and a subsequent reduction in antibiotic usage. This is an area of continuous improvement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: CI

Evidence:

A quality initiative is in place at Parkwood Lodge aimed at the accurate diagnosis of infections and reducing the inappropriate or unnecessary use of antibiotics. An analysis of infections in 2013 evidenced possible inappropriate prescribing of antibiotics for urinary tract, soft tissue and mucosal infections, related to misdiagnosis of an infection in long term care facilities. Implementation of an education programme to RNs regarding infection classification and accurate diagnosis of actual infections, as well as more localised treatments for wounds has resulted in a reduction in urine and soft tissue infections and a subsequent reduction in antibiotic usage which is sighted in graphs of infection data.

Finding:

Implementation of a quality initiative regarding the accurate diagnosis and classification of infections has resulted in a decrease of infections and decrease in antimicrobial usage.

Corrective Action:

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