

# The Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board

---

Current Status: 15 September 2014

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

## General overview

The Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board has been providing care for 64 years. It offers rest home, hospital and secure dementia care for a total of 247 clients.

The day-to-day operation of the facility is overseen by a general manager (GM) who reports directly to the Board of Trustees of which there are eight members. Clinical care oversight is managed by the quality development manager (QDM) who holds a current nursing annual practising certificate. Both staff members are experienced and qualified for the roles they undertake.

There were two areas identified for improvement in the previous audit and these have been addressed. There were no areas identified for improvement in this current spot surveillance audit. The quality and risk management standard has gained a continuous improvement rating as the service can demonstrate actions taken above those required to meet the standard, including ongoing evaluation processes.

The requirements of the provider's agreement with the district health boards are met.

## Audit Summary as at 15 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

Indicator	Description	Definition
	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 15 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.
--	--	--

### Organisational Management as at 15 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.		All standards applicable to this service fully attained with some standards exceeded.
---	--	---

### Continuum of Service Delivery as at 15 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.
--	--	--

### Safe and Appropriate Environment as at 15 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.
--	--	--

### Restraint Minimisation and Safe Practice as at 15 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.
---	--	--

## Infection Prevention and Control as at 15 September 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

# 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

<b>Legal entity name:</b>	The Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board		
<b>Certificate name:</b>	The Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board		
<b>Designated Auditing Agency:</b>	The DAA Group Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Caughey-Preston Hospital; Marianne Court; Upland Home; Ventnor Home		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 15 September 2014	<b>End date:</b> 15 September 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			239

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	4
<b>Other Auditors</b>	XXXXXX XXXXXXXX	<b>Total hours on site</b>	16	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	14	Total audit hours	38
Number of residents interviewed	9	Number of staff interviewed	16	Number of managers interviewed	5
Number of residents' records reviewed	10	Number of staff records reviewed	11	Total number of managers (headcount)	7
Number of medication records reviewed	20	Total number of staff (headcount)	292	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

I, XXXXXXXXXXXX, 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	Yes
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 Thursday, 9 October 2014

## Executive Summary of Audit

### General Overview

The Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board has been providing care for 64 years. It offers rest home, hospital and secure dementia care for a total of 247 clients. On the day of audit there are 20 clients in the secure dementia care area, 68 rest home level care and 151 hospital level care clients.

The day-to-day operation of the facility is overseen by a general manager (GM) who reports directly to the Board of Trustees of which there are eight members. Clinical care oversight is managed by the quality development manager (QDM) who holds a current nursing annual practising certificate. Both staff members are experienced and qualified for the roles they undertake.

There were two areas identified for improvement in the previous audit and these have been addressed. There were no areas identified for improvement in this current spot surveillance audit. The quality and risk management standard has gained a continuous improvement rating as the service can demonstrate actions taken above those required to meet the standard, including ongoing evaluation processes.

The requirements of the provider's agreement with the district health boards are met.

### Outcome 1.1: Consumer Rights

Policies and procedures identify and include all clients' rights to full and frank information being provided as defined in the Open Disclosure Policy. The service can demonstrate that client rights are met during service delivery. Interpreter and translation services are available and can be accessed as required.

The service implements a fair and easily accessible complaints management system which is understood by clients and family/whanau. Policies and procedures are implemented by the service to ensure all complaints are managed accordingly. Currently the service is awaiting one coroners final report findings from January 2014.

### Outcome 1.2: Organisational Management

The Board of Trustees (the Board) sets the strategic direction of the organisation and this is reviewed two yearly. The service undertakes an annual planning cycle, which involves members of the management team, where decisions are documented on how each area will link into the strategic direction of the organisation. Individual areas set goals and outcomes that are approved at senior management level. The outcomes which identify how clients' needs are met are reported and reviewed by the GM monthly.

The service has a quality clinical ethical committee which initiates and oversees all long term quality improvements. Forward planning 'road shows' seek staff input into actions that improve client services. The organisation's vision, mission statement, values and improvement pathways involve clients, staff, systems, resource management, and stakeholders from across all service areas.

Having fully attained the quality and risk management systems requirements the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and client

safety and satisfaction as a result of the review process. Quality and risk management systems are understood and implemented by staff. This area has gained a continuous improvement rating.

Adverse events are documented and identify that family/whanau are notified as appropriate. Client and family/whanau interviews conducted confirm service users are happy with the level of care and services provided.

Human resources management processes meet legislative requirements. Staff report they are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education. On-site education is conducted for all staff and includes a regular monthly clinical training day.

The service implements staffing levels and skill mixes that meet contractual requirements.

### **Outcome 1.3: Continuum of Service Delivery**

Hospital Services: The client records in the hospital evidence the provider has implemented systems to assess, plan and evaluate the care needs of the clients. Care planning demonstrates clients and their family participate in care planning processes. The clients' needs identified, outcomes/goals are reviewed in the timeframes required or more frequently if there is a change in the client's condition. The service is well co-ordinated to promote team work and continuity of care. These findings are supported by the GP interviewed.

The activities programme is structured in the hospital and implemented in a planned and organised manner for the clients. The activities support the interests, needs and strengths of each client. One-on-one activities are provided as necessary. Clients and families interviewed confirm their satisfaction with the programme.

The service has an effectively managed and safe medicine management system which is developed and implemented in line with best practice, legislative requirements and appropriate guidelines. The policies and procedures have recently been reviewed and re-implemented with ongoing quality improvements. The general practitioners review all clients' medication records in the timeframes required and communicate with the registered nurses and the contracted pharmacy effectively. Staff administering medication have completed medication competencies and ongoing education in relation to medicine management.

The catering service is managed by an experienced catering supervisor and overseen by the general manager. Relevant policies and procedures are reviewed and there is evidence of dietitian review and input into the winter and summer menus. All client's individual dietary needs are identified, documented and reviewed on a regular basis. Weight monitoring occurs. Visual inspection evidences compliance with current food safety regulations and guidelines utilised. Staff have received training in food safety. Clients and family/whanau interviewed report satisfaction with the catering service for all services.

Dementia/Rest Home Services: Clinical services provided meet the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. Clients' care is regularly evaluated to ensure the clients' assessed needs and desired outcomes are being met. During interview, clients and family/whānau express a high degree of satisfaction with the care services provided.

The service provides planned activities which are meaningful to the clients and allows them to maintain or improve their strengths, skills and interests.



## 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	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	CI	
HDS(C)S.2008	Criterion 1.2.3.5	Key components of service delivery shall be explicitly linked to the quality management system.	CI	The service can demonstrate that all results from key components of service delivery data collected is followed up accordingly. Data results are managed and monitored for effectiveness via appropriate committees which consist of representatives from across all areas of the organisation to ensure continuous improvement can be achieved. All planning links into the organisation's planning process and is overseen by the GM who reports directly to the board of trustees.
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Information is shared with clients as appropriate via client meetings, the newsletter and on a one on one basis as is appropriate. This is confirmed during interview with nine of nine clients, four of four family/whanau members and 16 of 16 staff. The analysis of data is gained via use of acceptable tools and client satisfaction and safety are the prime objective of corrective actions. This is monitored by various committees that are part of the organisational set up and evaluation is clearly documented in meeting minutes sighted. Key performance indicators are used to benchmark data collected. Quality initiatives that are put in place can be tracked via meeting minutes until they are fully embedded into practice.
HDS(C)S.2008	Criterion 1.2.3.7	A process to measure achievement against the quality and risk management plan is implemented.	CI	Policy is implemented related to quality and risk management. Achievements of actions put in place are reported to the board and across the whole organisation via meeting minutes which can be accessed by all staff. The service can demonstrate that this process is fully embedded into everyday practice. All quality actions are examined and approved by the quality clinical ethical committee and achievement is monitored by the board as confirmed in meeting minutes sighted. The GM confirms that all actions must be shown to meet the organisational quality and risk management plan goals and be reflective of the organisation's vision, mission statement and values.

Code	Name	Description	Attainment	Finding
				<p>The documented strategy for continuous quality management identifies that all required standards are met, that the actions taken are reviewed by nominated groups, committees, at senior management level and by the board. The internal monitoring process is clearly set out and review and improvement of corrective actions and quality projects are identified. This process includes gaining feedback from service providers plus external professional advice as required, such as, use of infection control consultants.</p>
HDS(C)S.2008	Criterion 1.2.3.9	<p>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:</p> <p>(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;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	CI	<p>Any issue that is deemed a risk to clients is managed and monitored firstly by the client risk committee who discuss and develop measures to manage the risk. This reduces the risk of potential harm occurring to service consumers. Each service area maintains an up to date risk register and new risks are written up on a specific form to show how they will be managed. High level monitoring of all risks are undertaken by the quality clinical ethical committee and the senior management team. Evaluation occurs using a recognised tool so that the severity of risk and the probability of occurrence is decided, documented and informed to consumers as appropriate. The service minimises the opportunity for potential harm via ensuring informed consent, multidisciplinary team input and that all relevant information is gathered prior to corrective actions being put in place. The health and safety committee oversee and monitor everyday risk and review risk registers so that it is a living document and is updated as required.</p> <p>The service has a structured internal training and education programme to ensure all staff have the required knowledge and qualifications for the role they undertake to ensure services are delivered in a safe appropriate manner. The service has tertiary level in the Workplace Safety Management Programme via ACC.</p>

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

---

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures documented and implemented identify and include all clients' rights to full and frank information as per the Open Disclosure Policy. The policies are available to guide staff. Senior staff interviewed (two clinical support nurses and six registered nurses), are fully informed and aware of open disclosure and providing accurate and appropriate information. The general practitioner at interview ensures clients, and family/whanau, with consent, are kept well informed at all times.

Interpreter services and advocacy services are available and procedures are available to assist staff. Staff employed represent many nationalities and staff commented at interview they could translate/interpret if required and appropriate. The Auckland District Health Board interpreter services are also available to this provider.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisational policy and procedures are implemented to ensure clients' rights to a fair and responsive complaints process is upheld. Clients and family/whanau are informed of the internal and external complaints procedures during the pre-admission process and at the initial multidisciplinary team (MDT) review. The service has many options for all clients and visitors to lodge a complaint. They can be verbal, written, via the client committee, completion of the official complaints form or they can be placed in the suggestions boxes located in each reception area. Interviews with nine of nine clients (six rest home and three hospital level care) and four of four family/whanau members confirm they are informed of and understand their rights related to making a complaint. No negative comments were received on the day of audit.

Most complaints are managed by the clinical nurse managers who follow clearly set out procedural guidelines to acknowledge and resolve the complaint. Significant complaints are reported to the general manager (GM). If a formal investigation is required it is undertaken by the quality and development manager (QDM).

At the time of audit the service is awaiting the close off of one outstanding coroner's report which was opened in January 2014.

#### **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 Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board (the board), which consists of eight members, review all planning documents at least two yearly. The service undertakes an annual planning cycle involving all managers to develop and review strategic initiatives related to their areas within the organisation, against the board's strategic planning documents, to improve existing services where possible. The delivery plans developed by the annual planning process describe improvement actions to be taken, by whom, requirements needed to complete the actions and the desired outcomes. Associated documents include any risks identified that may prevent the delivery of the plan. This information is taken to the board by the GM. Once approved schedules of the delivery plans progress are reported on monthly to the GM who monitors each action to ensure it is on track.

Budget planning is undertaken by the finance committee and approved by the board. The service holds a future development workshop annually which is a 'road show' for all staff. This format is used to seek staff input into actions that may improve client services. Responses must fall within the identified values of the organisation and this process is inclusive of all areas - clients, staff, stakeholders systems and resource management. This ensures planned services are coordinated and appropriate to meet the needs of clients.

The GM has been in her position for over nine years and working within the health field since 1993. She holds accountancy qualifications. The QDM has been in her role since 2008 and holds a current nursing practising certificate. All members of management undertake ongoing education related to the roles they perform. They are supported by a team of appropriately qualified staff who form the management team.

#### **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 1.2.3: 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:** CI

**Evidence:**

Having fully attained the quality and risk management systems requirements the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and client safety and satisfaction as a result of the review process.

Policies and procedures sighted are maintained by the service to ensure all legislative requirements are met and that current best practice is reflected in content. They are reviewed at least two yearly. Policies identify next due date, who they are developed by, who has approved them, the date of issue, the last review date and next due review date. Only the GM has authority to place new policies and procedures on the electronic drive where they are stored. The GM stated that she deletes obsolete policies from the drive. A discussion was held related to storage of obsolete policies and procedures being kept in an electronic archived file in case it needs to be referred to at any time. This will be considered by the service. Staff interviews with 16 of 16 staff from across the organisation confirm they have access to policies and procedures in the areas that they work.

The organisation implements quality and risk management systems that reflect the principles of continuous quality improvement. All key components of service delivery are measured and monitored and areas where corrective actions are required remain on meeting minutes until evaluation of each process is completed. Interviews with 16 of 16 staff (the kitchen supervisor, one cleaner, three healthcare assistants (HCAs), six RN, the infection control coordinator, two clinical support nurses, one allied health services manager, one activities coordinator and one diversional therapist) confirm their understanding of the quality systems which are in place at the facility.

The service has a client risk committee which monitors and oversees clinical areas such as moving and handling techniques and restraint. They also oversee any new projects related to client care. Audits are conducted as identified on the annual audit calendar. All audits are directed and managed by the quality clinical ethical committee. Monthly audit results are presented and discussed and any follow up for corrective actions are evaluated from feedback gained from clinical staff, allied health staff and other services as appropriate. If a corrective action does not have the desired outcome it is reviewed at senior management level and new corrective actions are documented and implemented. This is identified in meeting minutes sighted.

Meeting minutes sighted includes actions taken in response to quality data collection, health and safety, complaints management and incident and accident reporting. For example, meeting minutes show that staff moving and handling techniques for the use of a slide sheet when dealing with dependent clients is being imbedded into everyday practice. The process of quality management is closely monitored by the QDM who reports to the GM and the board who are kept fully informed as appropriate.

The quality improvement data which is collected and evaluated is benchmarked against previously collected data so that actions are taken to ensure continuous quality improvements occur.

Actual and potential risks related to the business operations are identified, documented and communicated to clients, family/whanau and staff as appropriate. The service has an up to date hazard recording system which identifies any hazards that are found and what actions have been taken to isolate, minimise or eliminate them. Hazards are recorded on a specific hazard identification form which identifies the controls put in place and the ongoing assessment of the effectiveness of the actions taken. The health and safety committee ensure the implementation of all hazard control issues to maintain a safe environment for all. One example relates to a leak in one sluice room. Actions taken included the display of signage alerting people to the incident and once the leak was fixed it was closed out. This is identified in health and safety committee minutes. If a hazard cannot be eliminated it is placed onto the hazard register which is regularly reviewed by the committee.

The service uses a 'plan, do, check act' (PDCA) cycle for review of all risks to ensure they are managed safely and that the best possible outcome is obtained.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** CI

**Evidence:**

Key components of service delivery are explicitly linked to the quality management system and are embedded into everyday practice.

**Finding:**

The service can demonstrate that all results from key components of service delivery data collected is followed up accordingly. Data results are managed and monitored for effectiveness via appropriate committees which consist of representatives from across all areas of the organisation to ensure continuous improvement can be achieved. All planning links into the organisation's planning process and is overseen by the GM who reports directly to the board of trustees.

**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:** CI

**Evidence:**

Quality improvement data are collected, analysed and evaluated to ensure information is used to improve service deliver. Staff have access to all results and follow up actions.

**Finding:**

Information is shared with clients as appropriate via client meetings, the newsletter and on a one on one basis as is appropriate. This is confirmed during interview with nine of nine clients, four of four family/whanau members and 16 of 16 staff. The analysis of data is gained via use of acceptable tools and client satisfaction and safety are the prime objective of corrective actions. This is monitored by various committees that are part of the organisational set up and evaluation is clearly documented in meeting minutes sighted. Key performance indicators are used to benchmark data collected. Quality initiatives that are put in place can be tracked via meeting minutes until they are fully embedded into practice.

**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:**

The service has a clearly documented system in place to measure achievement of quality actions and risk management that is reflective across the organisation.

**Finding:**

Policy is implemented related to quality and risk management. Achievements of actions put in place are reported to the board and across the whole organisation via meeting minutes which can be accessed by all staff. The service can demonstrate that this process is fully embedded into everyday practice. All quality actions are examined and approved by the quality clinical ethical committee and achievement is monitored by the board as confirmed in meeting minutes sighted. The GM confirms that all actions must be shown to meet the organisational quality and risk management plan goals and be reflective of the organisation's vision, mission statement and values.

The documented strategy for continuous quality management identifies that all required standards are met, that the actions taken are reviewed by nominated groups, committees, at senior management level and by the board. The internal monitoring process is clearly set out and review and improvement of corrective actions and quality projects are identified. This process includes gaining feedback from service providers plus external professional advice as required, such as, use of infection control consultants.

**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: CI**

##### **Evidence:**

The organisation has a well-documented process which is implemented across all services that addresses and manages identified and potential risks.

##### **Finding:**

Any issue that is deemed a risk to clients is managed and monitored firstly by the client risk committee who discuss and develop measures to manage the risk. This reduces the risk of potential harm occurring to service consumers. Each service area maintains an up to date risk register and new risks are written up on a specific form to show how they will be managed. High level monitoring of all risks are undertaken by the quality clinical ethical committee and the senior management team. Evaluation occurs using a recognised tool so that the severity of risk and the probability of occurrence is decided, documented and informed to consumers as appropriate. The service minimises the opportunity for potential harm via ensuring informed consent, multidisciplinary team input and that all relevant information is gathered prior to corrective actions being put in place. The health and safety committee oversee and monitor everyday risk and review risk registers so that it is a living document and is updated as required.

The service has a structured internal training and education programme to ensure all staff have the required knowledge and qualifications for the role they undertake to ensure services are delivered in a safe appropriate manner. The service has tertiary level in the Workplace Safety Management Programme via ACC.

##### **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:**

Members of the senior management team are aware of their responsibilities with regard to reporting adverse or unplanned events to regulatory and statutory bodies. This is also shown in policy and procedures sighted.

All adverse or untoward events are recorded on incident and accident forms. A review of the incident forms identify that all incidents are reported to family/whānau as appropriate. This is confirmed during interview with four of four family/whānau members and in ten of ten client file reviews.

All incident and accident forms are reviewed by the GM and QDM on a daily basis. Once they have been reviewed they are sorted into client care categories such as falls or skin tears and entered onto a data base. This information is then printed out and goes to the clinical risk committee for review and evaluation. Information gathered is benchmarked and used as an opportunity for improvement as appropriate.

Meeting minutes identify that incidents and accidents and related data are discussed at staff and management meetings.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Staff that require annual practising certificates have them validated prior to commencing work and annually thereafter. An electronic printout identifies when practising certificates are due and a letter is sent to staff to remind them of this. This includes clinical staff, podiatry, dietitian, occupational therapists and the physiotherapist.

The contracted GPs (from a service which is dedicated to managing aged care facilities) sign an employment contract stating they will take responsibility to ensure their annual practising certificates are kept up to date. This process is monitored by the GM who notes when practising certificates are due.

The orientation programme includes learning related to health and safety, back care, infection control, general knowledge, fire and emergency, confidentiality, complaints management, restraint, challenging behaviours, pressure area cares, falls management, promoting continence and ongoing education.

Employment documentation sighted in 11 of 11 staff file reviews includes a signed code of conduct form, police checks and reference checks, job description and signed employment contract indicating good employment practices are undertaken and legislative requirements are met. Interviews with 16 of 16 staff confirm that the service offers an appropriate orientation and ongoing education programme. Staff are supported and encouraged to undertake ongoing high level education. Two staff interviewed are being supported to do post graduate education. Each staff member has all their in-service education documented electronically and an annual printout from payroll is kept in each file. This is used to show any deficits in education and can be used for staff to identify training and education hours to governing bodies as required.

The service runs a monthly clinical training day which covers all mandatory education and is open to clinical staff. Matters of interest are also included in the education presented and content is kept on file and evaluated by staff following each session. Staff confirm the education offered is relevant to the roles they undertake.

Clients and family/whanau interviews confirm they are very happy with the services provided and that all their identified needs 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Provider levels skills mix is implemented as stated in policy. District health board contractual staffing levels are met.

A review of rosters and discussion with members of senior management identify that there is at least one RN on each shift and that staff sickness and annual leave is covered accordingly. A consistent level of care is offered from a wide skill mix of experienced and skilled staff to ensure client needs are met. Clinical staff are required to hold valid first aid certificates and this is monitored via management. On call senior management staff are shown on rosters and are available 24 hours, seven days a week if required.

HCAs who work in the dementia care unit hold appropriate recognised qualifications, such as Aged Care Education in dementia (ACE).

Staff report during interview that they have time to complete required tasks within rostered hours.

Interviews with nine of nine clients and four of four family/whanau members confirm they are happy with the level and standard of care provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Hospital: Service delivery documentation is overseen by the nurse manager and the clinical support nurse for the hospital. The client records are reviewed at regular intervals to ensure documentation is completed within the required timeframes. Five of five hospital clients' records evidence a high standard of record management. All client file entries are dated, signed and designations are documented. Signatures can be verified on the specimen signature lists sighted.

The registered nurses are responsible for the initial assessment and client profile and the comprehensive nursing assessments for each client on admission to this service. The multidisciplinary team are responsible for their respective assessments to be performed on each client; the general practitioner (GP) for the medical assessment, the physiotherapist assessment and environmental assessment and the activities co-ordinator for the social and activities assessment. The initial care plan is developed for each client and within three weeks the long term client centred care plan is developed and implemented.

Additional recognised clinical assessment tools used include falls risk checklist and management plan, pressure area (Waterlow), continence, pain and challenging behaviour. The clinical support nurse at interview reported that two interRAI nurse assessors have recently been employed full time to assist with the interRAI momentum assessments and care planning. The current long term care plan template is personalised individually for each client to meet their identified needs. The (Auckland District Health Board A+) Needs Assessment Service Co-ordinators (NASC) assessment prior to entry to this service for all clients is taken into consideration when developing the long term care plans. The care and support plans reviewed are comprehensive and cover personal grooming and dressing, safety, mobility and pressure risk, eating and drinking, elimination, communication, relationships and emotional support and spirituality, values and beliefs, social and activities.

Advanced care plans are discussed with the client in partnership with the general practitioner, if the client is cognitively capable to make care and treatment decisions independently. The GP at interview is well informed of obligations required when discussing advance care plans and advanced directives with the individual clients.

The clinical support nurse interviewed reports there is a process for six monthly reviews of the long term care and support plans. The registered nurses each have a list of clients in the hospital that they are responsible for. Responsibilities include the reviews of client's individual care support plans six monthly, or more often as required, and arranging the multidisciplinary reviews.

The three of three clients and two family interviewed provided positive feedback about the staff and general practitioners and report high satisfaction with the care and services provided to them in this hospital. A group interview of clinical staff (rest home and hospital combined), report they are kept up to date with all clinical changes and that team work and continuity of care is encouraged and promoted. There is an experienced nurse practitioner (NP) from ADHB who is readily available to this hospital service to provide advice and support if and when required.

The district health board contract requirements are met.

Tracer Methodology Hospital:

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

Tracer methodology Rest Home:

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

Tracer Methodology Dementia:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (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 1.3.6: 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:**

Hospital: The five of five hospital level clients' records reviewed evidence and record intervention that are consistent with the clients' identified needs and client centred goals set. Observations indicate clients receiving appropriate care and management. The two clients in the hospital interviewed report they are involved in their own care and feel they are treated as an individual. The staff interviewed ensure they are able to clearly identify the needs of the clients and with family input as required provide the necessary cares, support and assistance for all clients in their care in this hospital. The two of two family at interview expressed their satisfaction in how the service meets the needs of the clients. Interventions are monitored and reviewed by the clinical support nurse and/or the registered nurses and with the client/family input make the necessary changes if not appropriate.

The hospital service has adequate dressing and continence supplies to meet the needs of the clients. Appropriate re-assessments are performed and are sighted in the five of five individual client's records reviewed.

The general practitioner at interview discussed care and management of the clients and the effective communication of the clinical support nurse and staff registered nurses. The three of three healthcare assistants interviewed with six of six registered nurses report that the care and support plans are accurate, up-to-date and do identify and reflect the individual client's needs. As an example, each individual aspect of care for each client is clearly documented under each client centred goal and the appropriate intervention is documented to guide the health care assistants.

The district health board contract requirements are met.

Dementia /Rest Home: The five of five care plan reviews identify that the interventions recorded are consistent with the clients' assessed needs and desired goals. Observations on the day of audit indicate clients are receiving care that is consistent with their needs.

The file of the one resident reviewed clearly shows interventions related to all identified medical, nursing and personal needs. The interventions put in place to meet clients' needs are monitored by staff to ensure they have a positive result towards the client meeting their identified goals.

Interviews with six of six clients and two of two family/whānau member confirm they are very happy with the services that are in place and that all their needs are met.  
An interview with the GP confirms that staff deliver services in a professional, caring manner to ensure client needs are met.  
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:**

Hospital: Policy is in place relating to obtaining the relevant information for social interests and activities. This is included as part of the initial assessment for each individual client admitted to the hospital service. Information of each client's activity needs and choices is gathered and regularly reviewed thereafter. Relevant information is shared with the members of the multidisciplinary team.

The Allied Health Services Manager who is a registered occupational therapist (OT) and an assessor for the New Zealand Diversional Therapist Society (NZDTS) interviewed explained the process for managing the activities programme for the rest home and the hospital services. The allied health service manager is overall responsible for managing the staff responsible for covering this aspect of service delivery.

There are eight staff employed for the social and activities programme for the rest home services and for the hospital. Four staff are fully trained diversional therapists, three are trainees and one staff member is very experienced and skilled but has not undertaken any formal activities training. Four activities personal are rostered onto the hospital service to cover the specific programme developed and implemented for the hospital level clients. Each month one of the four activities co-ordinators has the role of being the 'Rover' activities co-ordinator each day for that particular month. This role has recently been introduced in the hospital. This role enables one of the activities co-ordinators to spend time with the more frail clients or those that cannot participate in the group activities organised. One on one activity is organised for respective clients as needed. The

activities co-ordinators attend monthly meetings to organise the weekly activities. Audits are undertaken of the activities programme as part of the internal auditing system for quality improvement.

The five physiotherapist-assistants do exercises for fun and fitness (free wheelers) for both rest home and hospital clients. Activities are planned for the hospital clients seven days a week, with lesser hours on Saturday and Sunday.

There is a programme developed and implemented by the activities co-ordinators which was reviewed. The programme reviewed is varied and interesting and is displayed in various locations around the hospital's six wards. The programme is based on the 'Eden Philosophy' although the hospital programme is more structured. The focus is on socialising with special events and community spirit projects. Groups, school children, pre-school level children and older students undertaking various youth schemes such as 'The Duke of Edinburgh Awards' are welcome to this facility as part of the activities programme. Other popular activities included happy hour, music sessions and housie.

There are no client meetings held for the hospital level clients but every three months a family meeting is held in the evening and all families are invited to attend. The minutes of each meeting is recorded and are available.

The district health board contract requirements are met.

Dementia /Rest Home: Five of five client file reviews show that activity assessments are undertaken as part of the admission process and updated six monthly or to reflect clients' changing needs. The activities coordinator reports that activities are developed to maintain clients' skills and strengths and those individual strengths and skills are supported, such as gardening or knitting. If a client does not wish to attend any of the daily activities the activities coordinator spends one on one time with the client.

Activities include church sessions, outings and happy hour. Client meetings are held two monthly and chaired by the activities coordinator. Meeting minutes sighted identify client input to the planning process.

The monthly activity planner is displayed on the notice board in the lounges. The six of six clients and two of two relatives interviewed report satisfaction with the activities programme and stated they attend many of the activities offered.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(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:**

Hospital: Reviews and ongoing assessments of clients by the clinical support nurse and the registered nurses covering the hospital service are clearly documented in the five of five client records reviewed. The medical consultations are clearly documented on the medical clinical records sighted. Documentation reflects the care and support plans are evaluated at least six monthly or more often if required. Evaluations are client focused and indicate the degree of achievement or response to support/interventions in place. The progress towards meeting the desired outcomes is reviewed. If a client is not responding appropriately to the interventions being delivered, or their health status changes, then this is discussed with the respective GP or the GP covering at the time. Generally two GPs visit the hospital each day of the week. A team of doctors covers the after-hours and weekends for the facility inclusive of the hospital.

Client`s changing needs are clearly described in the five of five care and support plans reviewed. Short term care and support plans are available and sighted for wound care management, skin tears, pain management, changes in mobility, changes in food and fluid intake requirements, weight loss and skin cares. These processes are documented in the medical and nursing assessments and in the client`s individual progress records.

The multidisciplinary reviews are organised by the registered nurses and families are invited to attend or contribute to the review process. Two of two family and three clients from the hospital confirm their input into the MDT meeting. Family members report that they can consult with the staff at any time if they have concerns or if there is a change in the client`s condition. The GP, nursing staff, activities co-ordinator and physiotherapist-assistant are able to contribute and to be involved.

The family communication contact document located in the front of each individual client record clearly evidences contact with family occurs if progress is different than expected or for information provided and/or communicated to the family.

The district health board requirements are met.

Dementia/Rest Home: Evaluations are documented, client-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. Nursing reviews and assessments, medical and specialist consultations are clearly documented. As shown in the review of the client care plan one rest home resident was reassessed for dementia care.

Five of five client file reviews identify that a minimum of six monthly evaluations are undertaken to ensure the interventions put in place are assisting to achieving the desired outcomes. If progress is different from that expected, changes are shown to client care plans or short term care plans are put in place. Interviews with three of three health care assistants and the RNs confirm any issues or concerns are discussed with the GP, the client and family/whānau as appropriate. This is supported during GP, client and family/whānau interviews.

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 1.3.12: 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:**

Rest home, dementia service and hospital: The organisation has appropriate policies and procedures in place to reflect safe and timely medicine management. The policies and procedures reviewed are available on-line in the hospital and individual rest home facilities provided on site. The quality and development manager at interview stated

that there has been a recent complete review of the medication management system. All policies and procedures have been signed off by the general manager and are to be implemented the day after the audit. New processes have been developed for example; around the eight rights of medicine management, managing urgent telephone changes, controlled drug management and the guidelines for the use of XXXXX have been reviewed. All policies and procedures are accessible to all clinical staff inclusive of the healthcare assistants.

Pharmacy reconciliation and review of each individual client's medication chart is undertaken at least six monthly. The medications are checked when the robotic medication packs are prepared at the pharmacy and prior to delivery to the facility. A further check of the medication packs is performed by two registered nurses in both the rest homes and the hospital on night duty when the medication is delivered to each service area. The robotic medication system utilised in all areas is a safe medication system and the lunchtime medication rounds were witnessed in both the hospital and in one of the rest homes. The medication trolleys are securely stored when not in use. Medication fridges in all clinical areas are monitored on a daily basis.

The 20 of 20 medication records (10 rest home and 10 hospital) evidence signing sheets are dated, signed off and signatures can be verified with the specimen signature list sighted. Photo-identification is observed on each record sighted. Allergies and sensitivities are recorded appropriately. Alert stickers are available. Signature specimen lists are in the front of each medication folder for the medical and nursing staff for verification if required.

There is clear evidence that the medication records are reviewed three monthly or more often as required. The GP interviewed confirms there is a system in place for the reviews. The GPs medical council registrations are recorded and all annual practising certificates for all health professionals are reviewed and a copy is retained by management. The 20 of 20 medication records reviewed are recorded accurately by the medical staff and when discontinued are ruled through dated and signed off appropriately. Any expired medicines or medication not currently in use is returned to the contracted pharmacy. The controlled drugs are checked weekly in the rest homes and hospital wards every Wednesday as per the protocol.

There are no clients self-medicating. The six of six registered nurses at interview understood the policy and process should this situation arise. No standard orders are observed. The staff responsible for medication management have all completed medication competencies and on-going education relating to medication management as verified on the education record spreadsheet reviewed.

The district health board contract requirements are met.

Dementia and Rest Home: The service uses robotic packs which are dispensed for each individual client by the pharmacy to match what is prescribed by a medical practitioner. Administration practices were observed for a lunch time medicine round which evidence good practices are followed in accordance with organisational policies. Ten of ten medication file reviews identify that there is a list of specimen signatures on each signing sheet. All staff who administer medicines hold a documented annual competency.

The service implements reconciliation processes which include the checking of all blister packs for accuracy by the RN's when delivered to the facility; all medication charts are faxed to the pharmacy and checked against the medical review updates every three months. There are processes in place to rotate the stored medicines to ensure they do not expire.

The GP conducts medicine reconciliation when clients are admitted to the service and at least three monthly thereafter. Ten of ten medicine file reviews show that each medication is individually signed.

Policy identifies that clients may self-administer medicines if they are competent to do so. Currently there are no clients who self-medicate. The service has controlled drugs in use and there is a controlled drug register which is reviewed as required. There are no standing orders in place.

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:**

Food service: Policies and procedures are available that include food safety and all aspects of food service management. The catering supervisor at interview explained the responsibilities for managing this service. The catering supervisor is an experienced chef and there is adequate staff to provide the service appropriately seven days a week. The general manager is overall responsible and can be consulted if and when required.

On visual inspection food is stored effectively and safely. Food monitoring of all the fridges and freezers occurs on a daily basis and records are maintained and are available for review. All equipment and resources are readily available inclusive of personal protective items such as gloves, hats and aprons. The kitchen is large and areas are designated for food preparation, plating /tray system serving areas, clean and dirty areas as required. The kitchen is very clean. Daily cleaning schedules are met by the staff in all areas of the food service. This is clearly evident with the orderlies cleaning the trollies after lunch in the trolley bay outside. Rubbish is stored appropriately and disposal processes are in place. Waste management protocol is followed.

On admission to the services rest home and hospital a nutritional assessment is performed by registered nurses and a copy is provided and retained by the kitchen manager. Any special dietary requirements or special diets are recorded and acknowledged by the kitchen staff when preparing the individual meals. Birthday cakes are made when clients` celebrate this occasion.

The main kitchen is centralised and is some distance from the hospital and the individual rest homes on site. All meals are prepared on trays for delivery to the appropriate areas in hot boxes. Each tray has a tray ticket which is completed for each meal and when served up is placed on the tray when delivered to the clients. Orderlies are responsible for this area of service delivery. Each area of service has their own kitchen with resources as required. The orderlies deliver the hot boxes to each area and the staff give out the individual trays. The dementia service (Marianne Court) is managed differently than all other services and the actual food is delivered to the service in bairmies and the clients serve up the meals under supervision of the staff, as a normal day to day event for the lunchtime mealtime. Additional food is always available and provided for the twenty four hour period for the dementia service and for other services as required.

Dining areas are available in the hospital wards, rest home and in the dementia service. These are set up before each mealtimes and the clients are seated appropriately.

Evidence of menu reviews being undertaken by a registered dietary service contracted to provide advice and support is available. Two yearly the winter/summer menus are reviewed. The menu review is based on the dietitian NZ audit for nutrition and dietary variety. Ministry of Health guidelines for older adults and Australian standardised definitions for texture modified food and fluids. The catering supervisor at interview reports all staff attending relevant education on infection control, first aid and safe food handling certificates. Interviews with four families (two dementia unit and two hospital) and nine of nine (six rest home and three hospital) clients indicate that there is overall satisfaction with the food services provided.

The district health board contract requirements are met.

Dementia /Rest Home Care:

Food services are implemented according to food safety policies and procedures. Clients nutritional needs are met by the provision of meals as shown in a registered dietitian menu which is reviewed two yearly.

The client admission process includes a dietary profile which identifies client's food and nutritional needs, wants, likes and dislikes. The cook confirms all clients' needs are catered for, including dietitian requests, food supplements, special diets and cultural needs. All instructions related to dietary needs are available to all staff in the kitchen. Interviews with six of six clients and two of two family/whānau member confirm they are very happy with food services and all their needs are met. All aspects of food procurement, production, preparation, storage and transportation meet current legislation and guidelines. Daily fridge and freezer temperatures are within normal ranges.

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.

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

**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.

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

**Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All monitoring is undertaken to meet legislative requirements to maintain the services current building warrant of fitness which was issued on 6 July 2014. There have been no changes made to the facility footprint since the previous audit.

### 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.)*

# 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:**

The service is maintaining its commitment and practice of restraint minimisation. The philosophy and practice of restraint minimisation is appropriate for the consumer group and service setting. There are systems and processes for implementation if restraint or enablers are required. When a client's condition deteriorates and their safety is compromised, they are reassessed for transfer to another more appropriate service (confirmed by interview with the RNs and health care assistants). There are five clients who require enablers. Staff training on restraint prevention and managing challenging behaviours occurs at least annually and this is discussed at staff meetings and monthly management/Client Risk Committee meetings.

ARRC 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.)*

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

---

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

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

**Attainment and Risk:** FA

**Evidence:**

Rest homes, dementia service and hospital: Surveillance for infection is carried out in accordance with agreed objectives, priorities, and the methodology that is specified in the infection control programme documented for all areas of service across this large aged care residential care organisation. The surveillance programme reviewed is appropriate for the size and nature of the services provided. The infection control policies and procedures are available on line but are accessible in all service areas to guide staff.

The infection control co-ordinator (ICC) is a senior registered nurse with valuable experience and knowledge in infection prevention and control. The infection control co-ordinator and the quality development manager are both interviewed. The ICC explained the surveillance system, the role of ICC, responsibilities and the reporting systems in place. Information gained is reported as part of the quality management system requirements (quality meetings) and quality improvement objectives on a monthly basis. The ICC maintains a risk register and records any outbreaks in any of the services. The ICC and the GP interviewed are aware of any reporting obligations and who to contact.

Infection control data is collected in the dementia unit, the individual rest homes and each individual hospital ward. Relevant types of infection such as urinary tract infections, lower respiratory infections, influenza, chest, skin and wound infections, oral infections, shingles and other infections. Surveillance forms have been developed and implemented for this purpose. The infection reports are completed and reviewed individually by the ICC. Any immediate trends, advice or information fact sheets are provided back to the service concerned. A surveillance summary and a newsletter is provided by the ICC monthly to each service area. Tool box sessions are held on a regular basis.

The ICC then enters the information electronically onto the reporting data base system. The service has a code for entering the relevant data to the contracted infection prevention control specialist. A second data base is utilised which evidences in graph form the number of infections reported per 1000 bed days for the year and this was sighted for the first eight months of 2014. The information forwarded is used for benchmarking purposes and this organisation is then benchmarked against other like-services. This information is forwarded quarterly to the contracted service provider. Additional advice and support on infection control matters can be sought from the microbiologist at Middlemore Hospital (CMDHB) a private Infection Control Nurse Consultant and the four general practitioners contracted to this service.

The three of three health care assistants at interview reported that they are kept well informed and understand their responsibilities for reporting any signs and symptoms of a client having an infection to the registered nurses or to the clinical support nurses directly.

#### 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:** 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.)*