# Kapiti Retirement Trust

## Current Status: 15 October 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

Sevenoaks Lodge is certified to provide hospital (medical and geriatric), rest home and dementia level care for up to 59 residents. There are 40 dedicated hospital beds, 12 dementia beds and seven respite beds (hospital and rest home level). On the day of audit there were 40 hospital level residents, 12 residents in the dementia unit and seven rest home level respite residents.

Sevenoaks is run by a non-clinical CEO and a registered nurse group manager. Both are well qualified for their roles. Staff turnover remains low. There are well developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

A continuous improvement has been awarded around the outcomes from falls initiatives.

The finding from the certification audit around incident reporting has been closed out and the finding around documentation of interventions to reflect the resident’s current status remains. This audit identified one additional improvement required around activity plan evaluations.

## Audit Summary as at 15 October 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 15 October 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 October 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. |

### Continuum of Service Delivery as at 15 October 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

### Safe and Appropriate Environment as at 15 October 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 October 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 October 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. |

# 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:** | Kapiti Retirement Trust |
| **Certificate name:** | Kapiti Retirement Trust |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Sevenoaks Lodge |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care) |
| **Dates of audit:** | **Start date:** | 15 October 2014 | **End date:** | 15 October 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:** | 59 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXXX | **Hours on site** | 9 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 9 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 18 | Total audit hours off site | 14 | Total audit hours | 32 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 120 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Monday, 3 November 2014

## Executive Summary of Audit

**General Overview**

Sevenoaks Lodge is certified to provide hospital (medical and geriatric), rest home and dementia level care for up to 59 residents. There are 40 dedicated hospital beds, 12 dementia beds and seven respite beds (hospital and rest home level). On the day of audit there were 40 hospital level residents, 12 resident in the dementia unit and seven rest home level respite residents. This makes a total of 59 residents on the day of audit. Sevenoaks is run by a non-clinical CEO and a registered nurse group manager. Both are well qualified for their roles. Staff turnover remains low. There are well developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

A continuous improvement has been awarded around the outcomes from falls initiatives.

The finding from the certification audit around incident reporting has been closed out, and, the finding around documentation of interventions to reflect the resident’s current status remains. This audit identified one additional improvement required around activity plan evaluations.

**Outcome 1.1: Consumer Rights**

Family are informed when the resident health status changes. There is a documented process for making complaints and residents, family and staff interviewed are able to discuss the complaints process. Complaints are recorded on a register that includes the complaint, action taken and sign-off.

**Outcome 1.2: Organisational Management**

Sevenoaks is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including six monthly quality committee meetings. An annual resident satisfaction survey is completed and there are family and resident meetings six monthly. Quality performance is reported to staff at the various meetings which include a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. A continuous improvement has been awarded around the outcomes from falls initiatives.

**Outcome 1.3: Continuum of Service Delivery**

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are evaluated six monthly. The resident/family/whanau confirm they are involved in the care plan process and review. The previous improvements required around documentation of interventions to reflect the residents current status remains. The activity team provides an integrated seven day week programme open to all residents to attend. The activities programme is varied, interesting and involves the families, volunteers, community visitors, entertainment and outings. There is allocated activity time for residents in the dementia unit based on sensory and every day activities that are meaningful for the resident. There are 24 hour activity plans for residents in the dementia care unit that is individualised for their needs. There is an improvement required around the review of activity plans. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. Meals are prepared on-site by a catering contractor. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

**Outcome 1.4: Safe and Appropriate Environment**

The Sevenoaks lodge holds a current warrant of fitness. There is reactive and planned maintenance. Hot water temperatures are monitored monthly with corrective actions taken as required. Electrical, mechanical and calibration checks are maintained for all equipment.

**Outcome 2: Restraint Minimisation and Safe Practice**

The restraint policy and procedure has a clear definition of restraint and enablers and includes a philosophy of restraint minimisation. There are 15 residents requiring restraint and four using enablers. Staff receive education related to restraint minimisation during orientation and as part of the education programme. Documentation is in place for assessment, approval, monitoring, review and evaluation of restraint.

**Outcome 3: Infection Prevention and Control**

There is an infection control policy that includes surveillance activities. Infections are reported and collated monthly. Infections and internal audit outcomes are discussed as part of the infection control meetings. Information is available to staff. The surveillance programme is appropriate to the size and complexity of the facility.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 1 | 38 | 0 | 2 | 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 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Two dementia care residents did not have interventions documented for (i) pain in legs as described in the progress notes. The same resident had no interventions documented for altered behaviour as identified in the written review, (ii) no short term care plan with interventions for resident with significant weight loss (1kg per month). Two hospital residents did not have interventions documented for (i) weight loss and changes in dietary requirements and (ii) no pain assessment or documentation for identified pain.  | Ensure interventions are documented to reflect the resident’s current health status.  | 60 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low |  |  |  |
| 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. | PA Low | The activity plans are not reviewed at the same time as the care plans.  | Ensure the activity plans are reviewed at the same time as the care plan.  | 180 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| 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 | The QPS data identified an average of 15 falls per month across the quarter October, November and December 2013. This led to the appointment of a dedicated ‘falls officer’ (enrolled nurse) who has been coordinating the project (interviewed). The falls officer maps the falls monthly identifying time, location and if injury was sustained. Information is left in the staff room. Information in respect of falls was discussed through staff newsletters and registered nurse meetings. Vitamin D was introduced where appropriate. At the time of audit here was a ‘toilet door’ talk relating to the project (sighted). One of the initiatives implemented as a result of the falls analysis has been twice a day walking with the residents (am and pm) in Kauri (dementia). This was introduced as the falls analysis showed a higher number of falls in the unit between 4-5pm. Review of the related PDCA evaluation noted: Resident’s calmer and sleeping better, falls have reduced, GP feels the initiative has been successful, residents are drinking well. The falls project is on-going. |

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms were reviewed across the 2014 period and where family had not been notified following a resident incident the form recorded: not notified as per open disclosure form. The form was seen to be in use in the files reviewed. Interview with four healthcare assistants inform family are notified following changes in health status.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b relatives (two hospital) stated that they are informed when their family members health status changes.
D11.3 The information pack is available in large print and this can be read to residents.

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

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

**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:**

There is a complaints policy to guide practice. The group manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) register that records activity in an on-going fashion. Complaints are discussed at the quality committee meetings, as well as the various other meetings within the service. Complaints forms are visible around the facility. There are two complaints for 2014 (and two across 2013), that are seen to have been investigated with updates to the complainant. Discussion with four residents and two relatives confirm they are aware of how to make a complaint.
D13.3h. a complaints procedure is provided to residents within the information pack at entry

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Kapiti Retirement Trusts' overall mission statement is “We preserve dignity, promote independence and provide choice". The business plan outlines the objectives for the trust.

Kapiti Retirement Trust (Sevenoaks Lodge) provides hospital - medical, geriatric, rest home, and dementia level care to residents across three units. There were seven rest home and hospital respite residents, 40 hospital residents and 12 dementia care residents. There were no residents currently under the medical component of their certification. The rest home beds have previously been assessed as suitable dual purpose. The service reported 334 ‘residents’ through the respite unit last year.

The CEO of the trust has many years’ experience in education and business management. She is responsible for the management of the village as well as the residential facilities. The clinical services are managed by a Group Manager Resident Wellbeing (GMRW) who is a registered nurse and been with the trust for nine years. The GMRW reports monthly to the CEO on clinical/operational matters who in turn reports monthly to the board. Interview with the chair of the board was positive about the reporting framework and level of information provided about the service by the CEO/managers.

Each clinical area has a clinical manager, registered nurse (RN) including hospital, dementia and short stay (respite) and appropriately skilled staff in each area.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

ARC,D17.3di (rest home), D17.4b (hospital), the CEO & GMRW has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.3: 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 has a strategic direction that has been communicated to staff. There is a business plan and annual quality and risk plan 2014. The quality and risk management system is implemented across each of the units. Policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

Quality matters are managed through a number of committees including health and safety, infection control, restraint and quality. Meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends). The clinical manager short term care & quality (registered nurse) oversees and manages quality activities. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. The service is part of the QPS programme and benchmark against various indicators including (but not limited to): falls injury, falls no injury, skin tears, medication errors, and infection rates. Benchmarking reports are generated quarterly throughout the year to review performance.

Sevenoaks is implementing an internal audit programme. Issues arising from internal audits are seen to have been followed up and closed. The service use the PDCA cycle as a quality improvement tool. Plans reviewed include initiatives around pain assessment tool; follow-up and improvements to policy in respect of a medication error; ‘toilet door’ education to raise staff awareness on topical issues e.g. melanoma.

The falls project has been a recent initiative the service is particularly pleased with and based on the reported resident outcomes a continuous improvement has been awarded.

Sevenoaks infection control and health & safety committees both meet quarterly. Infections (number and type) and health and safety matters – such as staff accidents - are discussed at the relevant committee meeting. Information is then taken to the quality committee and feedback going to staff meetings. Meeting minutes reviewed indicate issues raised are followed through and closed out, including family/resident meetings.

Annual surveys are undertaken – resident/family and employee satisfaction. The resident/family survey results for the past two years have rated the ‘overall view of the home’ at 98%. The 2013 results rated activities satisfaction at 84%, food services 83% and accommodation and living areas 85%. Quarterly newsletters for family/residents are developed.

Interview four health care assistants and three clinical managers were able to describe the quality system and how they receive information in respect of quality matters.

D19.3: There is a comprehensive H&S and risk management programme in place including policies to guide practice. The service has achieved tertiary accreditation (ACC).

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the appointment of a falls champion (refer 1.2.3.6).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** CI

**Evidence:**

Quality matters are managed through a number of committees including health and safety, infection control, restraint and quality. Monthly accident/incident data is collected including infections. The service participates in the QPS benchmarking programme and benchmark against various indicators including (but not limited to): falls injury, falls no injury, skin tears, medication errors, and infection rates. Benchmarking reports are generated quarterly throughout the year to review performance. The service use the PDCA cycle as a quality improvement tool to implement initiatives such as improvements to the service pain assessment tool; follow-up and improvements to policy in respect of a medication error; ‘toilet door’ education to raise staff awareness on topical issues e.g. melanoma. The service has had a particular focus on falls minimisation. Initiatives implemented into the dementia unit have seen a reduction in the number of falls. Sevenoaks infection control and health & safety committees both meet quarterly and results taken to the relevant staff meeting.

**Finding:**

The QPS data identified an average of 15 falls per month across the quarter October, November and December 2013. This led to the appointment of a dedicated ‘falls officer’ (enrolled nurse) who has been coordinating the project (interviewed). The falls officer maps the falls monthly identifying time, location and if injury was sustained. Information is left in the staff room. Information in respect of falls was discussed through staff newsletters and registered nurse meetings. Vitamin D was introduced where appropriate. At the time of audit here was a ‘toilet door’ talk relating to the project (sighted). One of the initiatives implemented as a result of the falls analysis has been twice a day walking with the residents (am and pm) in Kauri (dementia). This was introduced as the falls analysis showed a higher number of falls in the unit between 4-5pm. Review of the related PDCA evaluation noted: Resident’s calmer and sleeping better, falls have reduced, GP feels the initiative has been successful, residents are drinking well. The falls project is on-going.

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.3c: The service collects incident and accident data and reports aggregated figures through the quality committee. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the relevant clinical manager for final sign off. Family are notified when required. Ten incident forms were reviewed are seen to have been completed and closed as prescribed. In the files reviewed follow up is recorded in the progress notes following incidents and the finding from the previous certification audit is now closed.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files were reviewed (clinical manager dementia unit, lifestyle manager (diversional therapist), restraint coordinator (registered nurse), infection control coordinator (registered nurse), three healthcare assistants and one laundry person) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (three healthcare assistants, two registered nurses) were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is an annual education plan and annual compulsory training days that include the required education as part of these standards. The plan is being implemented. There is evidence that additional training opportunities are offered to staff such as syringe driver training and dialysis. Interview with three healthcare assistants confirm participation in the Careerforce training programme. A competency programme is in place that includes annual competency for medication, manual handling and infection control. Competencies are completed and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training.

There is a staff member with a current first aid certificate on every shift.

E4.5d: the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e: Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency

E4.5f: There are six healthcare assistants in the dementia unit and all have the required dementia standards.

##### 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:**

There are policy, procedures and guidelines that align with contractual requirements and includes skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents and relatives confirm there are sufficient staff on duty at all times. The health care assistant to resident minimum ratio in the hospital wing is 1-5, dementia unit 1-6 and respite wing is dependent on the number of residents and their acuity. The three clinical managers (registered nurses) work 32-40 hours per week, working at least one of their shifts on the floor. There is a registered nurse on duty 24:7 in the hospital wing with a second RN/EN on in the respite wing. There is dedicated housekeeping staff. Contractors manage food services and cleaning services. Minimum ratio in the hospital wing is 1-4/5.

##### 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:**

There is a policy and process that describe resident’s admission and assessment procedures.
D16.2, 3, 4: A registered nurse (RN) undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term care plan is developed in the four out of five resident files sampled (two hospital, two dementia, and one rest home respite). The respite care resident has a respite/palliative/convalescence nursing care in place within 24 hours of admission. The RN reviews the long term care plan six monthly or earlier if resident health status changes. Care plans are used by nursing staff and healthcare assistants to ensure care delivery is in line with the residents assessed needs. These are completed by the registered nurse (RN) with input from caregivers, the activities co-ordinators, family/whanau and any other relevant person.
Activity assessments, “life map” and the activities plans have been completed by the lifestyle and leisure manager (diversional therapist).

Four healthcare assistants (three hospital and one dementia care) interviewed could describe a verbal handover at the start of each duty that maintains a continuity of service delivery. Progress notes are written on each shift and significant events are recorded. All five files identified integration of allied health including physiotherapist, podiatrist, speech language therapist, community psychiatrist nurse and social worker. A physiotherapist is contracted for two to three hours a week.

Medical assessments are completed within 48 hours of admission by the GP in four of five resident files sampled. One resident is respite care. The GP (interviewed) is contracted to visit the service three times a week which includes three monthly reviews. The medical continuity of care has reduced the number of hospital admission due to early interventions. Residents may choose to retain their own GP. Respite care residents have their own GP attend them if required. The service provides discharge letters to the GPs of respite/palliative, convalescence care residents on discharge. There is liaison, referrals and involvement of allied health professionals (hospice, district nurses, speech language, continence and wound nurses) to provide a team approach to a planned discharge for each respite/palliative, convalescence care resident.

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Tracer Methodology: hospital resident

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

Tracer Methodology: Dementia care resident

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

Tracer Methodology: Respite care resident

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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:** PA Low

**Evidence:**

The service provides hospital, dementia care and respite/palliative/convalescence care. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. A range of assessment tools completed on admission are evident in the five resident files sampled including (but not limited to); a) dietary requirements and mini nutritional assessments, b) braden pressure area risk assessment, c) continence assessment, d) tinetti falls risk assessment, e) pain assessments including abbey pain scale, f) wound assessment, and g) behaviour charts and h) as applicable. Risk assessment tools are reviewed six monthly or earlier as required. Monitoring forms in place include (but not limited to); behaviour charts, weight and blood pressure and blood sugar levels. Weights are recorded three monthly. The previous partial achievement around documentation of interventions to reflect the resident’s current health status remains. Family interviewed (two hospital) confirm they are kept informed of any changes to their relative’s health status.

The four healthcare assistants (HCAs) and three registered nurses interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including hoists (checked March 2014), electric beds, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, mobility aids, weigh scales, gloves, aprons and masks.

D18.3 and 4; Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. Wound assessments are completed for wounds and skin tears. Treatment and appearance evaluations of wounds, including size are completed by the RN’s. Short term care plans are in place for two skin tears in the hospital and two skin tears in the dementia care unit (one resident). There are two minor wounds, one chronic wound and one pressure area of heel in the hospital unit. The chronic wound is linked to the long term care plan. Wound care advice is available to the RN’s. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the RN on duty could describe the referral process. There are adequate supplies of continent products in all areas.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. A range of assessment tools completed on admission are evident in the five resident files sampled including (but not limited to); a) dietary requirements and mini nutritional assessments b) braden pressure area risk assessment, c) continence assessment d) tinetti falls risk assessment e) pain assessments including abbey pain scale f) wound assessment and g) behaviour charts and h) as applicable. Risk assessment tools are reviewed six monthly or earlier as required. Monitoring forms in place include (but not limited to); behaviour charts, weight and blood pressure and blood sugar levels. Weights are recorded three monthly.

**Finding:**

Two dementia care residents did not have interventions documented for (i) pain in legs as described in the progress notes. The same resident had no interventions documented for altered behaviour as identified in the written review, (ii) no short term care plan with interventions for resident with significant weight loss (1kg per month). Two hospital residents did not have interventions documented for (i) weight loss and changes in dietary requirements and (ii) no pain assessment or documentation for identified pain.

**Corrective Action:**

Ensure interventions are documented to reflect the resident’s current health status.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a Lifestyle and Leisure manager employed and one full-time activity person. Both staff have completed diversional therapy (DT) units and will graduate inn December 2014. The activity team also includes two part-time activities persons who have completed dementia units through career force. The DTs attend two monthly regional and local DT support group meetings and workshops and attend conference. They attend on-site in-service and have current first aid certificates the team provide and implement the Monday to Saturday programme and are on-site on Sundays if there are special events, outings planned. There is an integrated programme which identifies time and activity for residents in the dementia unit. Dementia care residents are invited to attend activities and entertainment of interest only if supervision is provided. There are 50 volunteers involved in the activity programme such as crafts, canine friends, discussion groups, storytelling, reading, hand massage, word games, board games etc. There is a large activities room with a full kitchen for baking and several lounges and open plan dining/lounge areas where activities and exercises can take place. There are plentiful resources with crafts and photos displayed throughout the facility. Other activities on the programme include (but not limited to); movies, walkabouts, energise time, team bowls, crafty crew and cook’s corner. One on one time is spent with residents who are unable to participate in the group programme or those who prefer to stay in their rooms. Dementia care residents have twice daily walks (once in the morning and in the late afternoon). This has been a quality initiative for high risk falls residents and the number of falls in dementia unit have reduced through the walking programme. The outdoor area for dementia care residents includes raised herb gardens and chook house. The residents feed the chooks, collect the eggs and use them in baking. The male DT and male volunteers have a men’s group with activities such as restoring furniture, planting vegetables and making ginger beer. The ladies group are pampered with make-up, glamour shots and hand and nail care etc. Community links are maintained with mobile library visits, inter-home visits for trivia pursuit/picnics and other competitions. The service has a mobility wheelchair bus for regular outings for all residents. Musical entertainers and singers are booked weekly. Respite residents are funded to allow attendance at activities, outings and entertainment during their stay.

Interdenominational church services are held weekly as well as catholic communion on Fridays. Church members visit residents on a regular basis.

The DT’s complete a Life Map for each resident in consultation with the resident/family member as appropriate. An activity plan is developed within three weeks of admission

There are resident/family meetings held with management with positive feedback on the activity programme. Three hospital residents interviewed are complimentary of the varied and interesting programme.

D16.5d: There is an improvement required around the review of individual activity plans at the time of residents long-term care plan review.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The DT’s complete a Life Map for each resident in consultation with the resident/family member as appropriate. An activity plan is developed within three weeks of admission.

**Finding:**

The activity plans are not reviewed at the same time as the care plans.

**Corrective Action:**

Ensure the activity plans are reviewed at the same time as the care plan.

**Timeframe (days):** 180 *(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:**

There is an initial RN resident assessment. This is reviewed and a long term care plan is developed which is reviewed at least six monthly or earlier due to resident health changes. There is a three monthly review by the GP. There is documented evidence that six monthly care plan evaluations have been completed in two of two dementia care resident files and two of two hospital resident files. The respite resident file sampled identified the respite care nursing plan has been reviewed with each episode of care. Care plan reviews are signed as completed by an RN. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is on-going (link 1.3.6.1). Residents interviewed (three hospital and one respite care) and families (two hospital) confirm they have the opportunity to be involved in the review of their care plans.
D16.4a; Care plans are evaluated six monthly or more frequently when clinically indicated.
ARC: D16.3c; All initial care plans are evaluated by the RN within three weeks of admission.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. The service has three locked medication rooms (hospital, dementia care and respite unit). The supplying pharmacy is contracted to provide the medication blister packs for regular, PRN medications and other pharmaceuticals. The medications delivered are checked against the medication chart by an RN and one other medication competent staff member. Any discrepancies are fed back to the pharmacy. Expiry dates for PRN medications are checked monthly. There is a comprehensive medication reconciliation process for residents admitted for respite, palliative or convalescence care. The medication reconciliation form is faxed to the GP with supporting information and the medication chart completed and faxed to the pharmacy. The service has advice and input from the primary health organisations, district health board and pharmacy to develop the current system. Medication competent staff (RNs, enrolled nurses and senior HCAs) who administer medications complete annual medication competency assessments which includes a questionnaire and practical observations of medication rounds. Staff attend annual medication education. RN's in the hospital and respite care units have attended syringe driver training and annual refreshers. There is a current medication competent signature sheet. Standing orders are current. Antibiotic stock is held in the hospital unit for GP prescribing. There is one self-medicating resident in the respite unit. A self-medicating competency assessment has been completed and administration monitored. Eye drops in use in all medication trolleys are dated on opening. Medication fridges temperatures are monitored daily (records sighted). There are controlled drug safes in the hospital and respite care medication rooms. Controlled drugs for dementia care residents are accessed from the hospital unit. The hospital unit holds a bulk supply of medications including glucagon. There are weekly drug stock takes. Liquid controlled drugs are weighed before and after dispensing medication and weekly on specific weighing scales. There is a six monthly pharmacy audit. Oxygen and suction is available and checked each nightshift.
Ten medication charts sampled (four hospital, four dementia, two respite unit) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. All signing sheets are correct and PRN medications administered are dated, timed and signed. Controlled drugs administered are signed by two staff on the signing sheet (one of whom is a RN).
D16.5.e.i.2; Ten out of 10 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

##### 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 service is managed by the office manager (interviewed) for the contracted service. There are four staff on duty Monday to Sunday. This includes a cook, two kitchen assistants and a waitress/kitchen hand. The office manager is on-site Monday to Friday. An afternoon kitchen assistant completes the evening meal preparation. The menu is a four weekly seasonal menu that has been reviewed by a qualified dietitian. The main meal is at midday. End cooked meat temperatures are taken and recorded daily. The RN provides the cook with a resident’s dietary profile on admission and informs the cook if there are any dietary changes. Resident likes and dislikes are known with alternative choices offered. Dietary needs include soft/pureed and vegetarian. Meals are delivered to the hospital unit in bain maries ready for serving. Hot bain marie food containers are delivered in trolleys to the dementia care unit where staff serve the meals. The facility kitchen is well equipped with adequate pantry and dry good storage, chiller and freezers. Daily fridge, freezer and chiller temperatures are taken and recorded daily. All perishable foods sighted in chillers and facility fridges are date labelled. Electrical checks on equipment is carried out annually last in July 2014. Chemicals are stored safely. Staff are observed wearing correct protective clothing.

The service received feedback form the resident/family meetings and surveys. Residents interviewed state the food is very good and confirm there are alternative choices available. The contractor completes self-audits including serving temperatures. The service has a current council grading certificate issued 30 June 2014.

E3.3f, There is evidence that there are additional nutritious snacks available over 24 hours.
D19.2; Staff have been trained in safe food handling through the hospitality service industry (HSI).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Sevenoaks building holds a current warrant of fitness, which expires on 11 November 2014. A maintenance manager is employed to carry out preventative and planned maintenance within the facility. There is a maintenance request log book in each area for repairs and maintenance requests. Requests had been closed out/addressed within 48 hours. Electrical equipment has been checked and tagged next due August 2015. All electrical beds had mechanical checks June 2014. Clinical equipment including hoists have been checked/calibrated March 2014. Hot water temperatures are monitored monthly.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.
E3.3e: There are quiet, low stimulus areas that provide privacy when required.
ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, lifting aids, wheelchairs, chair scales.
E3.3e: E3.4.c: There is a safe and secure outside area that is easy to access for dementia residents.

##### 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.)*

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has four residents using an enabler in the form of bedrails and chair safety belt. The service currently has 15 residents that have been assessed as requiring restraint – either bed rails and/or chair safety belt. There are no residents in the dementia unit requiring the use of a restraint. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, restraint committee and facility meetings.

##### 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:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Short term care plans for infections are completed and kept in the resident file until the infection has resolved. All infections are entered onto a monthly infection analysis form. A monthly report is completed by the infection control co-ordinator, which is distributed to relevant meetings. Sevenoaks participates in the QPS benchmarking programme that includes infection rates. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

##### 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.)*