# The Ultimate Care Group Limited - Lansdowne

## Current Status: 14 November 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

Lansdowne Court Hospital and Rest Home (Lansdowne Court) provides rest home and hospital level care for up to 34 residents. There were 28 residents in Lansdowne Court on the day of this audit with 22 residents requiring hospital level care and six residents requiring rest home level care. All residents have spacious single room with their own ensuites. The facility is operated by Ultimate Care Group Limited.

No areas requiring improvement were identified during this audit.

## Audit Summary as at 14 November 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 14 November 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 14 November 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 14 November 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 14 November 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 14 November 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 14 November 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:** | The Ultimate Care Group Limited |
| **Certificate name:** | The Ultimate Care Group Limited - Lansdowne |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Lansdowne Court Hospital and Rest Home | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 14 November 2014 | **End date:** | 14 November 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:** | 28 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 7 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 6.5 | **Total hours off site** | 4 |
| **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 | 13.5 | Total audit hours off site | 10 | Total audit hours | 23.5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 8 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 50 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 0 |

## **Declaration**

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | 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 Tuesday, 25 November 2014

## **Executive Summary of Audit**

**General Overview**

Lansdowne Court Hospital and Rest Home (Lansdowne Court) provides rest home and hospital level care for up to 34 residents. There were 28 residents in Lansdowne Court on the day of this audit with 22 residents requiring hospital level care and six residents requiring rest home level care. All residents have spacious single room with their own ensuites. The facility is operated by Ultimate Care Group Limited. No areas requiring improvement were identified during this audit.

**Outcome 1.1: Consumer Rights**

Residents and families interviewed reported that services are provided in a manner that respects residents’ rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family following adverse events and any significant change in a resident's condition.

The Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information was displayed, along with complaint forms in a number of locations in the facility. The facility manager is responsible for complaints and a complaints register is maintained, with all complaints recorded. All complaints reviewed were at the lower level and all had been resolved satisfactorily.

**Outcome 1.2: Organisational Management**

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Lansdowne Court. The vision statement, values, quality objectives, quality and risk management plan, quality indicators and quality projects reflected a commitment to providing quality care to residents and are reviewed regularly. Systems were in place for monitoring the service provided at Lansdowne Court including regular monthly reporting by the facility manager to the Ultimate Care Group Head Office. The facility is managed by a suitably qualified and experienced manager who is an enrolled nurse with a number of years aged care experience. The facility manager started in this role three months prior to the audit and is well supported by an experienced clinical lead who is a registered nurse and responsible for oversight of clinical care.

There are policies and procedures on human resources management and all health professionals had the required current practising certificates. There was a comprehensive education programme in place. All care staff are required to complete the Aged Care Education (ACE) and ACE dementia programmes.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. There is 24 hour registered nurse cover. All care staff interviewed reported that there is adequate staff available and that they are able to get through their work.

**Outcome 1.3: Continuum of Service Delivery**

Assessing, planning and delivery services:

Lansdowne Court provides timely, planned, coordinated and appropriate services to its residents. A range of assessment tools were used to identify residents’ needs. Comprehensive and detailed care planning was completed by registered nurses in a timely manner, and was evaluated on a regular basis. The evaluation of residents’ progress was a strength of the service with evidence of resident/family input into these processes. Referrals were made to specialist services when additional support was required.

All residents were reviewed by the general practitioner at least three monthly, with additional visits organised if required. At least one registered nurse is on duty 24 hours a day, and they provide support and guidance to care delivery staff. All residents and family members interviewed expressed their satisfaction with the services provided.

Medication management:

The management of medications was safe and appropriate and complied with all legislative and professional requirements. All medications were administered by registered nurses, who had been assessed as competent in that role.

Food services:

The storage and provision of food was undertaken in a manner that met all food safety requirements and ensured that the nutritional needs of residents were being met. There was close monitoring of what residents were eating and of their nutritional status, including weight gain or loss. This was also a strength of the organisation. A new summer menu had just been implemented, which included the opportunity for residents to choose from two menu items for the evening meal. Resident satisfaction with the new menu will be reviewed one month after its implementation. There is a spacious and well-lit dining area for residents, although residents can eat in their own rooms if they prefer.

Activities:

A qualified, experienced diversional therapist coordinated the activities programme. Residents were individually assessed to identify their activity preferences, which were then reflected in their care plans, and evaluated on a regular basis. A range of activities were provided to residents, including exercises, games, current events, guest speakers, entertainers, and outings in the facility van. The diversional therapist reported that she individually invites residents to planned activities, but if residents do not wish to participate in activities this was respected.

**Outcome 1.4: Safe and Appropriate Environment**

The facility manager advised there have not been any alterations to the building since the last surveillance audit. A Building Warrant of Fitness was displayed at the main entrance and expires on 23 June 2015.

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

The facility has implemented a process of restraint minimisation for residents that is consistent with its policy. The service has maintained a process to determine approval for all types of restraint, including enablers. This was supported by consistent assessment, evaluation and monitoring of all types of restraint in use.

**Outcome 3: Infection Prevention and Control**

A robust process was in place for infection surveillance, and for responding to surveillance results. Infection surveillance data was captured using an electronic system, with results reported monthly to the quality committee, staff meetings, and the general practitioner. Surveillance data was also benchmarked with other Ultimate Care Group facilities.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# 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:**

The services provided by Lansdowne Court are conducive to an environment of effective communication.

Accident / incident monitoring reports reviewed, reported and recorded all types of incidents and included notification to families / whanau as appropriate.

The service has open disclosure and informed consent policies which provide guidance to staff around the principles and practice of open disclosure and informed consent. Staff confirmed they understand that relatives and residents must be informed of any changes in care provision. There were no residents at the time of audit that require interpreting services, however management were aware of how to access interpreters, through the NZTC (the international translation centre) if this service should be required. One example was given where the need for an interpreter was required recently. This was managed by the family with the assistance of a selected staff member who the family appointed as a person who they were comfortable with to assist when required.

On admission, the resident and their family/whanau have been given relevant information and a discussion was held to clarify what they wish to be informed about and at what time of day they wish to be notified.

Residents and family interviewed confirmed communication with staff was open and effective, that they were always consulted and informed of any untoward event or change in care provision.

ARCC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.13: 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 service has a detailed complaints policy and procedure that complies with Right 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). Training for all staff around the Code is included in the induction programme with ongoing training regularly scheduled. A flow chart is used to illustrate the process used for all complaints. The manager is advised immediately if a complaint is received, it is risk rated, logged into the national reporting system then entered into the complaints register. The investigation and responses sighted were all recorded along with the outcome.

A copy of the complaints procedure is included in the introductory pack for all new residents and there were forms located in three areas of the facility to ensure they are easily accessed.

Six complaints have been received so far this year and these were reviewed. All had followed the required process and had been satisfactorily resolved. This included one that had been sent to the Health and Disability Commissioner but it had been referred back to the organisation for internal resolution. This had also been resolved satisfactorily.

ARCC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the services provided at Lansdowne Court. The current Quality and Risk Management policy was reviewed and it includes a vision statement, core values, quality objectives, quality indicators and quality projects and scope of service. Also reviewed were documented values, mission statement and philosophy, which were displayed in the entrance area of the facility. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring residents to the service. These were last reviewed by the organisation in April 2014.

UCG has established systems in place which defines the scope, direction and goals of the organisation at UCG facilities, as well as the monitoring and reporting processes against these systems.

There is an Ultimate Care Group Clinical Advisory Group (CAG) in place. This comprises of three clinical services managers, one facility manager, two regional managers, the audit and compliance manager and clinical quality and Lead interRAI practitioner who are responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites.

The manager at Lansdowne Court has been in the position for three months after having had worked at the facility for three years. Prior to employment at the facility, the manager had managed another aged care facility in the area.

Twenty four hour registered nursing cover is provided. Support for the manager and the clinical lead is provided by a regional operations manager and the audit and compliance management team for UCG.

ARCC requirements for governance of the organisation are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.3: 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 Ultimate Care Group (UCG) Quality and Risk Management Plan is used to guide the quality programme and includes quality goals and objectives. The Ultimate Care Group (UCG) quality and risk management systems were in place at Lansdowne Court.

There is an internal audit programme in place and completed internal audits 2014 were reviewed. Review of quality improvement data provided evidence the data is being reported to Ultimate Care Group Head Office via the UCG intranet as well as to staff through various meetings. Separate quality improvement and staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. The quality committee is made up of the manager, the clinical lead, the maintenance person, the diversional therapist, a kitchen staff representative, the designated health and safety representative, and the restraint coordinator. This committee meets monthly prior to the staff meetings so all relevant information is able to be shared with all staff.

Month by month graphs of various clinical indicators are now being produced to inform staff of the trends and progress. All staff interviewed reported that they are kept informed of quality improvements. One initiative the manager has put in place is a ‘Fall Free’ day chart that is produced monthly to indicate progress in the area of fall reduction.

The manager reported that they are responsible for providing weekly and monthly to UCG Head Office and these include reporting of numbers of clinical indicators, education provided and internal audits completed. Other areas reported on include occupancy, staffing and HR, resident ‘ins and outs’, property/environmental issues, financial and general comments.

Relevant standards were identified and included in the policies and procedures manuals reviewed. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice and were referenced to legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The UCG clinical advisory group is responsible for reviewing policies and procedures. All old policies were archived appropriately. Care staff interviewed confirmed the policies and procedures provided appropriate guidance for the service delivery and they were advised of new policies / revised policies via handover and meetings.

When indicated corrective action plans were raised to address any areas of concern or where improvements could be made.

A Health & Safety Manual was available that included relevant policies and procedures. There was a hazard reporting system in use nationally and the facility hazard register was reviewed and was current.

ARCC requirements for quality and risk management are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The adverse event reporting system provided evidence of a planned and co-ordinated process. Staff document adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG quality system. They are then filed in both residents’ files and the facility register. All incidents were reviewed and analysed at the monthly quality meetings and any corrective actions identified to improve service delivery and mitigate any risks.

Documentation for the previous month was reviewed (11 incidents in total) and these all followed the required process with all actions and outcomes recorded, including notification of families.

Policy and procedures complied with essential notification reporting including health and safety, human resources and infection control. The manager demonstrated a clear understanding of what is required for essential notification reporting and the appropriate authorities to contact.

ARCC requirements for adverse event management are met.

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

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

**Attainment and Risk:** FA

**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 were well described human resources management systems at Lansdowne Court which included the recruitment and appointment of employees, orientation, training and on-going education, performance development and management and for associated good employment practices.

Written policies and procedures in relation to human resources management were available and reviewed. The skills and knowledge required for each position within the service was documented in job descriptions which outlined accountability, responsibilities and authority. These were reviewed on staff files along with reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments. The validation of current annual practising certificates for all registered nurses, enrolled nurses, the pharmacists, dietician, podiatrist and general practitioners is occurring and the practising certificate folder was reviewed.

Professional qualifications are validated during recruitment. A copy of the annual practising certificate (APC) for all qualified nurses employed by Lansdowne Court was also kept on their personnel file. Evidence of other qualifications (eg. Careerforce qualifications held by caregivers, the diversional therapist, food hygiene certificates) were maintained on personnel files. The files reviewed had the appropriate qualifications recorded.

There is a planned education programme which includes modules on restraint, the Code, infection prevention and control, challenging behaviours, wound care, back care, nutrition and continence. Annual medication competencies are included where indicated. All registered nursed must have current first aid certificates. The manager is an aged care education (ACE) assessor and reported that the ACE and ACE dementia programmes are required to be completed by all caregivers.

All staff members interviewed reported that they received appropriate training to be able to do their jobs safely and well. A new caregiver who was currently involved with the induction process, reported she was feeling well supported and her training was comprehensive. She was to spend at least four days on specific shifts and had been given an induction pack to work through that covered all the necessary elements of a relevant programme.

ARCC requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

The manager completes all the rosters for the facility and uses the ‘allocation of staff/duty rosters’ tool which is used across UCG. This ensures the allocation for hours and staff meets the required levels to reflect the needs of the residents who are currently in Lansdowne Court. This is sent off to the head office every Friday to show the level and skill mix rostered for the coming week. The manager completes all rosters ahead for a two week period and then rechecks just prior to each new week. If there are any queries the manager discusses these with the regional operations manager.

The rosters for the coming weeks were sighted and given the proximity of the Xmas period, the manager had drafted a roster to cover the periods up to 11 January.

These all showed sufficient staff levels and skill mixes were appropriate to meet the current residents’ needs.

ARCC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **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:**

Lansdowne Court used a comprehensive range of information to help guide staff in assessing, planning and then evaluating service delivery. An initial assessment and care plan was completed by a registered nurse within 24 hours of admission, with long-term nursing care plans developed by a registered nurse within three weeks of admission (sighted in five of five resident records – three hospital, two rest home). A range of assessments are undertaken as part of the care planning process (such as falls, pressure area risk and nutritional assessment) and there was evidence of regular reassessment being undertaken. The three residents interviewed confirmed their involvement in the assessment, care planning and evaluation process.

All new residents are medically admitted by the General Practitioner, and then reviewed six-monthly, or earlier if their needs change.

Service delivery was coordinated across the service by the Facility Manager and the Clinical Leader. A registered nurse was on duty 24 hours daily. The registered nurses complete a verbal handover at the start of each shift, followed by a handover for the health care assistants, along with a written handover sheet. All residents’ progress notes are updated each shift. Two communications were also in use (one for all staff, the other for registered nurses).

Tracer One (Hospital-level)

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

Trace Two (Rest Home)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:**

There was evidence in all residents’ records reviewed of regular, timely and ongoing assessment of needs which then informed the provision of care services. A range of assessments were completed by a registered nurse within the first three weeks from admission, building on the initial assessment and care plans were developed within twenty-four hours. The findings of the assessments were reflected in the comprehensive and individualised care plan developed for every resident. Resident reassessments were completed at least six monthly, but more often as clinically indicated (confirmed in resident records and staff interviews). One staff member has recently completed the interRAI training, with training organised for a second staff member.

There are registered nurses on duty at all time, who are available to support and guide care delivery staff. Three residents and two family members confirmed their satisfaction with the services provided to them, with one family member stating they would rate the care as a “twelve out of ten”.

##### **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:**

There was a well-developed and comprehensive activities programme at Lansdowne Court. A qualified diversional therapist, with more than ten years experience in the role, co-ordinates activities, undertakes resident assessments, develops activity plans, and evaluates those plans six monthly (as confirmed in the residents’ records). The activities coordinator visits residents individually to invite them to the days activities. The wishes of residents who do not want to participate in planned activities is respected. A daily record is also maintained of resident’s participation in activities (sighted).

A range of group activities are provided for residents (for example visiting entertainers, guest speakers, quizzes, church services, reading the newspaper and bingo). There are regular trips outside the facility, using the facility’s van. Seasonal and topical celebrations are incorporated into the activities programme, such as a recent Melbourne Cup activity. Care staff were also involved in supporting residents with activities.

The activities coordinator participates in a bi-monthly regional support group for diversional therapists, and also attends the annual diversional therapists conference. Residents interviewed confirmed their satisfaction with the activities programme.

##### **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:**

The evaluation of service delivery plans was a strength of the service. All of the care plans reviewed showed evidence of a thoughtful, timely and comprehensive approach to assessing resident progress towards their individualised goals. There was also strong evidence of changes in health status and/or functional ability being incorporated into the care plan, so that these plans remained current. Care plans were evaluated at least six monthly, and more frequently as clinically indicated.

##### **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:**

Appropriate medicine management processes were in place at Lansdowne Court to ensure that residents received medicines in a safely and timely manner consistent with legislative and safe practice requirements.

All medications were administered by registered nurses who have been assessed as being medication competent (records sighted). Medications are dispensed by the pharmacy using the blister pack system, and these are checked by a registered nurse on arrival at the facility (records sighted). Expired or discontinued medication is returned to the pharmacy.

Medications are administered to residents in a safe manner (medication round observed). There were no residents who were self-medicating. Prior to medicine administration, medicines are checked against the medication chart, and the resident is identified by the photograph in the medication folder and verbally (observed during a medication round). Records of medication administration were complete (sighted in four rest home and six hospital medication charts), and a signature log was maintained of all health professionals involved in the medication process. Medication charts are typed, and all included the resident’s NHI number, and allergy status. All medications had been individually signed by the prescriber, discontinued medications were signed and dated, and there was evidence of regular medication reviews by the prescriber. The facility no longer uses Standing Orders.

All medications in the medication trolley and stock cupboards were within current use dates, and all eye drops currently in use had the date of first use recorded. A weekly count of all controlled medications was undertaken (records sighted). The temperature of the medication fridge was monitored daily, and was maintained within appropriate temperature range (record sighted).

##### **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:**

An experienced cook, who has completed the relevant food safety training, leads the food service provision. All kitchen staff have completed recent food handling safety education (records sighted, confirmed by the facility manager).

A nutritional assessment and dietary profile was completed for each new resident on admission and then reviewed six monthly or earlier if required (sighted). The kitchen retained a copy of the resident’s dietary profile, and individual requirements, such as food dislikes or special diets, was recorded on the kitchen whiteboard. Specific dietary requirements, such as diabetic diets, soft diets, weight reduction or low potassium diets, were accommodated. A range of feeding equipment, such as lip plates, and specialised cutlery was sighted. A spacious and well-lit dining room was available to residents, although residents could chose to dine in their own rooms if they wished.

An inspection of the kitchen revealed that all food was being stored and prepared in a safe and hygienic manner. Detailed cleaning schedules are in place, including daily, weekly, monthly and six monthly schedules (sighted) with records maintained of the completed cleaning. Records were sighted of the daily monitoring of fridge and freezer temperatures, while the cook reported that the dishwasher was serviced six monthly. Systems are in place to ensure that residents have fresh fluids provided to them in their rooms on a daily basis, as well as the regular refreshments offered to them during the day.

The facility manager reported that there had been resident concerns over the meals recently, although only one of the three residents interviewed expressed any dissatisfaction with meal provision. The meal observed during the audit visit (lunch) looked appetising and was attractively presented to residents, with several reporting their enjoyment of the meal. The cook reported that she monitors verbal feedback about meals, there is a communication book for staff to record compliments and concerns, and the cook visits each resident every two months to obtain feedback and suggestions about meals. The facility manager reported a new summer menu, approved by a registered dietitian, has just been implemented, and will be reviewed once in place for one full month. The new menu includes two choices for the evening meal. Individual menu forms are given to each resident daily.

The monitoring of resident’s nutritional status was a strength of the service. When a resident required feeding or assisting with meals, a record was maintained of their food intake at each meal (sighted). Residents were weighed monthly and the percentage weight gain or loss was calculated. This data was closely monitored by the registered nurses, with strategies put in place as necessary (sighted in residents’ records).

##### **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 manager advises there have been no alterations to the building since the last audit. The current building Warrant of Fitness is displayed in the main entrance and expires on 23 June 2015.

##### **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 facility implements a process of restraint minimisation for residents. The policy sighted states the use of enablers as ‘voluntary use of equipment by a resident that limits normal freedom of movement with the intention of promoting Independence, comfort and safety’. There were three residents using enablers at Lansdowne Court at the time of audit. The files kept for the use of enablers were reviewed. The assessments and consents were sighted along with evidence of ongoing three monthly reviews and evaluation. The monitoring processes in place for each resident were sighted and these have been kept up to date with two hourly monitoring in place.

The restraint coordinator is a registered nurse who stated that the use of restraint was actively minimised. The restraint coordinator stated this has been achieved by the use of low beds, landing pads, bell mats and education. A comprehensive analysis of all residents that were falling frequently has also helped in the management of restraint use.

ARCC 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:**

The type of surveillance undertaken was appropriate for the size and complexity of the facility. Results of surveillance were acted upon, evaluated and reported in a timely manager (as confirmed in interview with the facility manager and two staff).

The infection control policy specified the infections to be monitored (eye, ear, nose, mouth, gastrointestinal, skin, wounds, urinary tract, upper respiratory tract, systemic). When infections are identified, appropriate action is taken to assist in achieving infection reduction and prevention. The surveillance data was entered into the Ultimate Care Group database. Surveillance data was reported monthly at the quality meeting and the next staff meeting, as well as to the general practitioner (confirmed by the facility manager, infection control policy and database printout). Surveillance data was also benchmarked with other Ultimate Care Group facilities.

##### **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.)*