Rosewood Resthome Limited

CURRENT STATUS: 22-Aug-13

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

GENERAL OVERVIEW

Rosewood rest home and hospital provides rest home dementia specific and hospital psychogeriatric level care to up to 66 residents. The facility is privately owned and operated with management provided by a general manager. The facility has three units - a 26 bed dementia specific unit with 18 residents on the days of audit; and two 20 bed psychogeriatric hospital units with 19 residents in each unit on the day of the audit. Each unit is managed by a clinical nurse manager with support from care staff, ancillary and administration staff. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family interviewed all spoke positively about the care and support provided.

Improvements required relate to reporting of all adverse events, conducting annual staff appraisals, provision of medication management training, re-assessments, aspects of medication management and ensuring that all medical equipment is calibrated and serviced.

AUDIT SUMMARY AS AT 22-AUG-13

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights	Day of Audit 22-Aug-13	Assessment
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	Day of Audit 22-Aug-13	Assessment
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		**Some standards applicable to this service partially attained and of low risk**

Continuum of Service Delivery	Day of Audit 22-Aug-13	Assessment
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 medium or high risk and/or unattained and of low risk**

Safe and Appropriate Environment	Day of Audit 22-Aug-13	Assessment
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.		**Some standards applicable to this service partially attained and of low risk**

Restraint Minimisation and Safe Practice	Day of Audit 22-Aug-13	Assessment
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	Day of Audit 22-Aug-13	Assessment
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**

AUDIT RESULTS AS AT 22-AUG-13

Consumer Rights

Rosewood rest home and hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented and logged in a complaints register.

Organisational Management

Rosewood rest home and hospital is privately owned and operated. A general manager is employed to oversee the management of Rosewood. The general manager is supported by three clinical nurse managers, registered nurses and care staff. The general manager and clinical nurse managers are responsible for the implementation of the quality and risk management programme. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. Corrective actions are implemented, documented and followed through to resolution. Incidents and accidents are discussed at management and staff meetings. An improvement is required whereby all

adverse events are recorded. Families are surveyed every two years and through three monthly resident/family meetings. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. An improvement is required whereby medication management updates are provided for staff. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. An improvement is required whereby all staff appraisals are conducted annually. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Documents are appropriately and securely maintained and stored.

Continuum of Service Delivery

There is a needs assessment completed prior to entry to Rosewood. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with family input and is coordinated to promote continuity of service delivery. Family interviews confirm their input into care planning, care evaluations and the resident having access to a typical range of life experiences and choices. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and families interviewed confirm that interventions noted in the residents care plans are consistent with meeting their needs. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan or alteration to the long term care plan. Improvement is required to ensure reassessment of all possible care needs is documented. Planned activities are appropriate to the resident group with a focus on individual activity. An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities. Staff responsible for medicine management has completed education on medication management. Improvement is required to ensure all staff who administer medications are assessed for competency at least annually and medications prescribed as required include a documented indication of use. A central kitchen and on site staff provide the food service for the home. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis.

Safe and Appropriate Environment

All building and plant comply with legislation. There is a maintenance person and comprehensive preventative maintenance programme including equipment and electrical checks. Improvement is required to ensure all medical equipment and devices are calibrated according to manufacturer recommendations to ensure accuracy of recordings and function. There are adequate numbers of toilets and showers across the facility with access to hand basins, liquid soap and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents rooms are spacious to allow care to be provided and for the safe use and manoeuvring of mobility aids including in en-suites. The facility is spacious with multiple large and small seating areas. Activities occur in a location suited to the type of activity. Furniture is arranged to ensure residents are able to move freely and safely in all areas. The service has implemented policies and procedures for fire,

civil defence and other emergencies. There are staff on duty with a current first aid certificate. The organisation provides housekeeping and laundry policies and procedures.

Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service currently has two hospital residents assessed as requiring restraint (one lap belt and one lap belt or waist harness). There is a restraint and enablers register. There are comprehensive restraint/enabler documentation completed including assessment, consent, individual planning, monitoring and review. Staff are trained in restraint minimisation and in managing challenging behaviours. Restraint is actively minimised and there is evidence of management review six monthly.

Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Rosewood Resthome and Hospital

Rosewood Resthome Limited

Certification audit - Audit Report

Audit Date: 22-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Rosewood Resthome Limited

Premise Name	**Street Address**	**Suburb**	**City**
Rosewood Resthome and Hospital	288 Woodham Road	North Linwood	Christchurch

Proposed changes of current services (*e.g. reconfiguration*)**:**

Type of Audit	Certification audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 22-Aug-13	**End Date:** 23-Aug-13
Designated Auditing Agency	Health and Disability Auditing New Zealand Limited	

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXX	RCpN,Health auditor,AdDipBusMan,CertQA	12.00	6.00	22-Aug-13 to 23-Aug-13
Auditor 1	XXXXXX	RN, Health Auditor	12.00	5.00	22-Aug-13 to 23-Aug-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXX	RCompN, PGDipHSM Lead auditor		2.00	

Total Audit Hours on site	24.00	**Total Audit Hours off site** *(system generated)*	13.00	**Total Audit Hours**	37.00
Staff Records Reviewed	9 of 68	**Client Records Reviewed** *(numeric)*	9 of 56	**Number of Client Records Reviewed using Tracer Methodology**	2 of 9

Staff Interviewed	13 of 68	**Management Interviewed** *(numeric)*	2 of 2	**Relatives Interviewed** *(numeric)*	10
Consumers Interviewed	0 of 56	**Number of Medication Records Reviewed**	18 of 56	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	2

Declaration

I, (full name of agent or employee of the company) XXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 4 day of September 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: ☒

The audit summary has been developed in consultation with the provider: ☒

Electronic Sign Off from a DAA delegated authority (*click here*): ☒

Services and Capacity

				Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
Premise Name	**Total Number of Beds**	**Number of Beds Occupied on Day of Audit**	**Number of Swing Beds for Aged Residential Care**	Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Rosewood Resthome and Hospital	66	56	0	☐	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐

Executive Summary of Audit

General Overview

Rosewood rest home and hospital provides rest home dementia specific and hospital psychogeriatric level care to up to 66 residents. The facility is privately owned and operated with management provided by a general manager. The facility has three units - a 26 bed dementia specific unit with 18 residents on the days of audit; and two 20 bed psychogeriatric hospital units with 19 residents in each unit on the day of the audit. Each unit is managed by a clinical nurse manager with support from care staff, ancillary and administration staff. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family interviewed all spoke positively about the care and support provided.

Improvements required relate to reporting of all adverse events, conducting annual staff appraisals, provision of medication management training, re-assessments, aspects of medication management and ensuring that all medical equipment is calibrated and serviced.

1.1 Consumer Rights

Rosewood rest home and hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented and logged in a complaints register.

1.2 Organisational Management

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1.3 Continuum of Service Delivery

There is a needs assessment completed prior to entry to Rosewood. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with family input and is coordinated to promote continuity of service delivery. Family interviews confirm their input into care planning, care evaluations and the resident having access to a typical range of life experiences and choices. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and families interviewed confirm that interventions noted in the residents care plans are consistent with meeting their needs. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan or alteration to the long term care plan. Improvement is required to ensure reassessment of all possible care needs is documented. Planned activities are appropriate to the resident group with a focus on individual activity. An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities. Staff responsible for medicine management have completed education on medication management. Improvement is required to ensure all staff who administer medications are assessed for competency at least annually and medications prescribed as required include a documented indication of use. A central kitchen and on site staff provide the food service for the home. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis.

1.4 Safe and Appropriate Environment

All building and plant comply to legislation. There is a maintenance person and comprehensive preventative maintenance programme including equipment and electrical checks. Improvement is required to ensure all medical equipment and devices are calibrated according to manufacturer recommendations to ensure accuracy of recordings and function. There are adequate numbers of toilets and showers across the facility with access to hand basins, liquid soap and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents rooms are spacious to allow care to be provided and for the safe use and manoeuvring of mobility aids including in en-suites. The facility is spacious with multiple large and small seating areas. Activities occur in a location suited to the type of activity. Furniture is arranged to ensure residents are able to move freely and safely in all areas. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The organisation provides housekeeping and laundry policies and procedures.

2 Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service currently has two hospital residents assessed as requiring restraint (one lap belt and one lap belt or waist harness). There is a restraint and enablers register. There are comprehensive restraint/enabler documentation completed including assessment, consent, individual planning, monitoring and review. Staff are trained in restraint minimisation and in managing challenging behaviours. Restraint is actively minimised and there is evidence of management review six monthly.

3. Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is

appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	FA	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	FA	0	2	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	FA	0	4	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	FA	0	3	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	FA	0	1	0	0	0	2
Standard 1.1.7	Discrimination	FA	0	1	0	0	0	5
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	FA	0	3	0	0	0	9
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	FA	0	2	0	0	0	2
Standard 1.1.13	Complaints management	FA	0	2	0	0	0	3

Consumer Rights Standards (of 12):	N/A:0	CI:0	FA: 12	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:23	PA:0	UA:0	NA: 0			

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	FA	0	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	PA Low	0	1	1	0	0	4
Standard 1.2.7	Human resource management	PA Low	0	3	1	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	FA	0	4	0	0	0	10

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 5	PA Neg: 0	PA Low: 2	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	

Criteria (of 34):	CI:0	FA:20	PA:2	UA:0	NA: 0

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	1	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	PA Low	0	0	1	0	0	5
Standard 1.3.5	Planning	FA	0	2	0	0	0	5
Standard 1.3.6	Service delivery / interventions	FA	0	1	0	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	Medicine management	PA Moderate	0	2	2	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 10	PA Neg: 0	PA Low: 1	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	

Criteria (of 51): CI:0 FA:18 PA:3 UA:0 NA: 0

1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances	FA	0	2	0	0	0	6
Standard 1.4.2	Facility specifications	PA Low	0	2	1	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	FA	0	1	0	0	0	5
Standard 1.4.4	Personal space/bed areas	FA	0	1	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining	FA	0	1	0	0	0	3
Standard 1.4.6	Cleaning and laundry services	FA	0	2	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	FA	0	5	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	FA	0	2	0	0	0	3

Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0
PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 36): CI:0 FA:16 PA:1 UA:0 NA: 0

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	FA	0	1	0	0	0	3
Standard 2.2.2	Assessment	FA	0	1	0	0	0	2
Standard 2.2.3	Safe restraint use	FA	0	3	0	0	0	6
Standard 2.2.4	Evaluation	FA	0	2	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	FA	0	1	0	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 6 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 21): CI:0 FA:9 PA:0 UA:0 NA: 0

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	FA	0	3	0	0	0	9
Standard 3.2	Implementing the infection control programme	FA	0	1	0	0	0	4
Standard 3.3	Policies and procedures	FA	0	1	0	0	0	3
Standard 3.4	Education	FA	0	2	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0
PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0

Total Standards (of 50) **N/A:** 0 **CI:** 0 **FA:** 45 **PA Neg:** 0 **PA Low:** 4 **PA Mod:** 1 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0

Total Criteria (of 219) **CI:** 0 **FA:** 95 **PA:** 6 **UA:** 0 **N/A:** 0

Corrective Action Requests (CAR) Report

Provider Name: Rosewood Resthome Limited
Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:22-Aug-13 End Date: 23-Aug-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.2.4	1.2.4.3	PA Low	**Finding:** A heel pressure injury which developed for one dementia unit resident was not reported via the incident reporting system. **Action:** Ensure that all adverse events, including pressure injuries, are reporting via the incident reporting system to provide opportunities for improvement and review of resident care requirements.	3 months
1.2.7	1.2.7.5	PA Low	**Finding:** a) Medication management training has not been conducted since February 2011; b) Annual appraisals have not been conducted for all employees. **Action:** a) Provide education and training for staff around medication management; b) Ensure all employees have annual performance appraisals conducted.	6 months
1.3.4	1.3.4.2	PA Low	**Finding:** Two of three dementia rest home and four of six PG files reviewed did not include a completed assessment tool for challenging behaviour on admission. Three of three dementia rest home and four of the six PG resident files reviewed did not include a documented assessment for challenging behaviour as a part of the evaluation process. Four of six PG resident files reviewed did not include routine reassessment of nutrition and or pain. **Action:** Ensure reassessment of all possible care needs is documented.	3 months
1.3.12	1.3.12.1	PA Moderate	**Finding:** Not all PRN medications prescribed included a documented indication of use.	1 month

			Action: Ensure all as required medications include a documented indication of use.	
1.3.12	1.3.12.3	PA Low	**Finding:** Not all registered nurses and caregiver staff who administer medications have been had competency reassessed annually. **Action:** Ensure all staff who administer medications are assessed for competency at least annually.	3 months
1.4.2	1.4.2.1	PA Low	**Finding:** Not all medical equipment and devices had been calibrated to ensure accuracy of recordings and functions. **Action:** Ensure all medical equipment and devices are calibrated according to manufacturer recommendations to ensure accuracy of recordings and function.	6 months

Continuous Improvement (CI) Report

Provider Name:	Rosewood Resthome Limited
Type of Audit:	Certification audit
Date(s) of Audit Report:	Start Date:22-Aug-13 End Date: 23-Aug-13
DAA:	Health and Disability Auditing New Zealand Limited
Lead Auditor:	XXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The code of rights is incorporated into care. Discussions with six caregivers (two dementia, four psychogeriatric (PG) identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with 10 family members (three dementia and seven PG) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in October 2012.

Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

Code of rights leaflets are available at the front entrance of the rest home dementia unit and the entrances into the two PG units. Code of rights posters are on the walls in the hallway of the facility. Client's right to access advocacy services is identified for families and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents depending on their level of cognitive function. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in nine of nine files reviewed (three dementia and six PG).

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

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission.

Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated.

Rosewood rest home and hospital's philosophy values relate to the provision of holistic care services meeting the physical, social, emotional and spiritual needs of the residents. Dignity and privacy will be maintained and family will be included at all times and a team caring approach is encouraged. There is a policy that covers abuse and neglect and staff have completed training in March 2012.

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

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

E4.1a Three dementia unit families' states that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a Nine of nine resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

ARHSS D4.1b Six PG resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The service has established cultural policies to help meet the cultural needs of its residents including recognition of Maori values and beliefs, Maori health plan, Tikanga policy, and Treaty of Waitangi policy. The rights of the resident to practise their own beliefs is acknowledged in the policies and procedures. The plans and policies have been developed in consultation with Maori advisors.

There are presently four residents who identify as Maori - two dementia unit and two in PG unit one. The service has access to a comprehensive cultural assessment appropriate to Maori needs and details whānau input around the initial assessment and care plan development and reviews. Rosewood identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors and local iwi advocacy services as identified in the Maori health policy and plan.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the registered nurse with the inclusion of the family / whānau. The service identifies opportunities to involve family/whānau in all aspects of planning individuals service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with the three clinical nurse managers, one registered nurse and six caregivers confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately. Cultural safety and Treaty of Waitangi training last provided June 2013. One clinical nurse manager identifies as Maori and acts as a resource person for staff, residents and families.

A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).

D20.1i: The service has developed a link with local iwi for advisory and advocacy services. There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually.

Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The service's philosophy focuses on residents' right to be accepted as an individual and being given the opportunity to enhance the values in their lives thereby enables residents to be individuals. This flows through into each person’s care plan and could be described by six caregivers (two dementia, and four

PG) interviewed. During the admission process, the registered nurse along with the family/whanau complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. Ten family members (three dementia and seven PG) interviewed advised that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day.

D3.1g The service provides a culturally appropriate service by carrying out a cultural assessment on admission with family/whānau involvement when available and by implementing the philosophy of the service.

D4.1c Nine care plans reviewed included the residents social, spiritual, cultural and recreational needs.

ARHSS D4.1d: Six PG care plans reviewed included the residents social, spiritual, cultural and recreational needs.

Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment.

Performance appraisals are conducted (with exceptions- link #1.2.7) and staff receive supervision. Discussions with 10 family members (three dementia and seven hospital) identify that privacy is ensured.

Discussions with six caregivers (two dementia, four PG) described how professional boundaries are maintained. Discussions with the general manager, three clinical nurse managers and a review of complaints, identified no complaints of this nature.

ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with four PG unit caregivers could describe how they build a supportive relationship with each resident. Interviews with seven family from the PG unit confirmed the staff assist to relieve anxiety.

Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

A2.2 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are provided by an external consultant, who provides regular updates for the service to maintain best practice. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through residents meetings, staff appraisals (see CAR 1.2.7), satisfaction audits, education and competencies, complaints and incident management.

There is an internal audit schedule. It includes (but is not limited to): admission, care plan, complaints, continence, cultural and spiritual, environment and equipment, hygiene and grooming, infection rates, informed consent, laundry and cleaning, medications, privacy and safety, staff training, restraint, weights and nutrition and wound care.

Ten family members (three dementia and seven PG) interviewed spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for the care givers and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions.

Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

There is an open disclosure policy, a complaints policy, an accident/incident policy and adverse events policy. Ten family members (three dementia and seven hospital PG) stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly in each unit and the general manager and the clinical nurse managers have an open-door policy.

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 The 10 family members (three dementia and seven PG) interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.

D11.3 The information pack is available in large print and advised that this can be read to residents

ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. The information booklet is relevant to the psychogeriatric units. It provides information for family including practical information for families.

Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Policies and training support staff in providing care and support so that residents are involved in the service to the level of their ability. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interview with six caregivers and four RNs (one RN and three clinical nurse managers), identify that consents are sought in the delivery of personal cares and residents are not compelled to carry out any activity or task. This is confirmed by 10 family members (three dementia and seven PG) and two GP's interviewed. Written consent is gained from enduring power of attorneys for each resident and includes the signed admission agreements, consent for outings and care plans. All nine resident files reviewed has signed outing and EPOA forms.

D13.1 Admission agreements were signed and on file in all nine files reviewed.

D3.1.d Discussion with 10 family identified that the service actively involves them in decisions that affect their relatives lives and they are well informed of all matters pertaining to their family member.

Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Client right to access advocacy services is identified for residents and families. Leaflets are available at the entrances of each unit. The information identifies who can be contacted to access advocacy services. The information pack provided to families prior to entry includes advocacy information.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided in October 2012.

D4.1d; Discussion with 10 family members (three dementia and seven PG) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

ARC D4.1e, ARHSS D4.1f: Nine of nine resident files reviewed include information on resident's family/whanau and chosen social networks.

Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

D3.1h ARHSS D16.5f: Discussion with three clinical nurse managers, one registered nurse, six caregivers (two dementia, four PG), and 10 family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with the diversional therapist described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, church services, family outings. Entertainers are included in the activities programme. The diversional therapist and clinical nurse managers described how outings in the facility owned van are tailored to meet the interests of the residents.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to family/whanau. A complaints/compliments folder is maintained with all documentation. The general manager is responsible for complaints management. Complaints are discussed at monthly management meetings and monthly staff meetings. The complaints register demonstrates that both verbal and written complaints are actively managed. Two have been received in the past two years and were reviewed. One relates to the quality of the evening meal and the other relates to a respite resident's care. Both complaints evidence that appropriate communication and actions have been taken. Documentation is maintained with letters of reply to complainants. Ten family members (three dementia and seven PG) advised that they are aware of the complaints procedure and how to access forms. Families are given the opportunity to discuss concerns either face to face with the general manager or clinical nurse managers, via written complaint forms or at the three monthly resident/family meetings held in each unit.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, challenging behaviour management and complaints policy.

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

Rosewood rest home and hospital is privately owned and operated. A general manager is employed to oversee the day to day operations of the facility. The general manager is a registered nurse with experience in management, mental health, and dementia care. Each of the three units (one dementia specific and two psychogeriatric - PG) is managed by a registered nurse - clinical nurse manager. The general manager and the three clinical nurse managers make up the management team and are responsible for quality and risk management. The general manager reports to the owners on a fortnightly basis. The mission statement for Rosewood includes the desire to "ensure that Rosewood is a comfortable cheery environment for the residents and that the care is of the highest standard and appropriate for dependent people suffering from dementia related illnesses. We endeavour to create a living and working environment, which promotes dignity and respect". The documented philosophy values relate to the provision of holistic care services meeting the physical, social, emotional and spiritual needs of the residents. Dignity and privacy will be maintained and family will be included at all times and a team caring approach is encouraged. The facility provides care for up to 66 residents - 26 rest home dementia and 40 (two units of 20) hospital psychogeriatric (PG). On the days of audit there were 18 rest home dementia residents and 38 PG residents - 19 in each PG unit.

The service has a current strategic plan and a quality and risk management plan for 2013. The quality programme is managed by general manager and the three clinical nurse managers with assistance from the owner. The general manager and the owner meet fortnightly to discuss financial, business, staffing and occupancy matters. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The management team meetings monthly to assess, monitor and evaluate quality care at Rosewood. There are clearly defined and measurable goals developed for the strategic plan and quality plan.

ARC E2.1, ARHSS D5.1 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), ARHSS D17.5 the manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.

D15.3d: The three clinical nurse managers have maintained at least eight hours annually of professional development activities related to managing a rest home dementia or PG unit.

Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

During a temporary absence of the general manager, the clinical nurse manager from PG unit two provides temporary facility management. In the absence of any of the clinical nurse managers, the units are covered by the another manager. The clinical nurse managers are all registered nurses and are experienced in aged care, dementia care and management. The service has well developed policies and procedures at a service level and a strategic plan and quality improvement plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home dementia and hospital psychogeriatric level care.

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

ARHSS D4.1a: The service operational plans, policies and procedures promotes a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.

Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☒ SQ ☐ STQ ☒ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The service has a quality assurance and risk management programme for 2013 and this is being implemented. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly management meetings, and monthly staff meetings in each unit. The management meeting agenda and the staff meeting agendas includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Management meeting minutes sighted for 14 August 2013, and staff meeting minutes sighted for dementia unit - 11 July 2013; PG unit one on 13 June 2013; and PG unit two on 19 July 2013. Minutes include actions to achieve compliance where relevant. The quality assurance and risk management programme objectives relate to client focused services, high standards of care, education for staff, and creating a happy, cheerful and harmonious atmosphere. An annual review of the quality programme for 2012 was conducted in February 2013.

Further quality improvement activities identified for 2013 include a falls prevention programme, a plan to reduce the prescribing and use of PRN medication (see CAR 1.3.12), six monthly case conferencing for all residents and the introduction of Vitamin D for all rest home level residents. This, together with staff training, demonstrates Rosewood's commitment to on-going quality improvement. Discussions with three clinical nurse managers, one registered nurses and six care givers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly in each unit.

Audits are conducted in each unit and include: admission, care plan, complaints, continence, cultural and spiritual, environment and equipment, hygiene and grooming, infection rates, informed consent, laundry and cleaning, medications, privacy and safety, staff training, restraint, weights and nutrition and wound care. Audits for 2013 have been completed and there is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and handover times.

The service has a health and safety management system and this includes the identification of a health and safety officer. There are health and safety representatives in each unit. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by the clinical nurse managers who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the unit staff meetings, the monthly management meeting.

A next of kin satisfaction survey and a staff satisfaction survey is conducted two yearly (last conducted September 2012). Results from the next of kin survey have been collated and a comprehensive action plan developed to address the areas of service short fall. Clinical nurse managers have been responsible for implementing the actions and improvements. The results were discussed at a full management meeting (10 October 2012) with the owner present. Follow up and review of the implementation of the action plan is discussed at each subsequent management meeting. All corrective actions are now signed off as completed. Resident and family meetings are held in each unit three monthly. Minutes sighted for dementia unit meeting 18 June 2013; PG unit one - 18 April2013; and PG unit two - 6 June 2013.

There is an infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

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

D19.2g Falls prevention strategies such as falls risk assessment, walking aids, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring in the lounge areas and sensor mats if required.

D5.4 The service has the following policies/ procedures to support service delivery; Policies and procedures align with the resident care plans. Policies are provided by an external quality consultant who provides the service with regular updates. The management team is responsible for policy review.

Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:** Low

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** PA Low

There is an accident/incident policy which includes reporting and management of all incidents, accidents and near misses. Exception reports are completed for incidents and accidents which are then investigated and analysis of incidents trends occurs. Each clinical nurse manager is responsible for conducting investigations in to incidents. There is a discussion of incidents/accidents at monthly management meetings and monthly unit staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Incident reports for July 2013 were reviewed. A sample of exception reporting forms for each unit were reviewed and include predominantly falls, behaviours, and skin tears. Care givers commence the exception reporting form, with RN assessment and care management. Each clinical nurse manager completes follow up and ensures that all necessary actions have been documented and completed. Six exception reports were reviewed (two dementia unit and four PG). All evidenced that family notified as appropriate, assessment and care provided by registered nurse, with appropriate referrals made for acute care, wound care, GP review, further care or reassessment. A record of the incidents is recorded in progress notes and on the family contact sheet. On review of one rest home dementia resident file, it was note that a heel pressure injury developed in March 2013. However, this was not reported and followed up via the incident reporting system. Improvements are required in this area. Monthly incident/accident analysis occurs with subsequent annual summary and analysis.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: PA **Risk level for PA/UA:** Low

There is an accident/incident policy which includes reporting and management of all incidents, accidents and near misses. Exception reports are completed for incidents and accidents which are then investigated and analysis of incidents trends occurs. Each clinical nurse manager is responsible for conducting investigations in to incidents. There is a discussion of incidents/accidents at monthly management meetings and monthly unit staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Incident reports for July 2013 were reviewed. A sample of exception reporting forms for each unit were reviewed and include predominantly falls, behaviours, and skin tears. Care givers commence the exception reporting form, with RN assessment and care management. Each clinical nurse manager completes follow up and ensures that all necessary actions have been documented and completed. Six exception reports were reviewed (two dementia unit and four PG). All evidenced that family notified as appropriate, assessment and care provided by registered nurse, with appropriate referrals made for acute care, wound care, GP review, further care or reassessment. A record of the incidents is recorded in progress notes and on the family contact sheet.

Finding Statement

A heel pressure injury which developed for one dementia unit resident was not reported via the incident reporting system.

Corrective Action Required:
Ensure that all adverse events, including pressure injuries, are reporting via the incident reporting system to provide opportunities for improvement and review of resident care requirements.

Timeframe:
3 months

STANDARD 1.2.7 Human Resource Management

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met?

Attainment: PA Low

The annual leave and rostering policy includes staffing levels and skill mix. Reference checks are conducted to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses and general practitioners is kept (sighted). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed and include the general manager, three clinical nurse managers, three caregivers, the cook and senior diversional therapist. Advised that reference checks are completed before employment is offered as evidenced in three recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Six care givers (two dementia, four PG) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. All new staff complete the induction/orientation training. Orientation checklists evident in nine of nine staff files reviewed.

Discussion with the general manager, three clinical nurse managers, RN training coordinator and six caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Six caregivers interviewed have completed the ACE core and dementia training programme. The registered nurses are able to attend external training including conferences, seminars and sessions provided by the local DHB. Advised by the RN training coordinator that he is responsible for ensuring that all care staff complete the ACE core and dementia unit standards. One to one and group education is conducted for this programme.

Education provided in 2013 includes: oral health, challenging behaviours, infection control, fire and emergency procedures, IC reverse barrier nursing, cultural safety, and complaints management. Education completed in 2012 included safe moving and handling, dealing with complaints, abuse and neglect, communicating with people with dementia, restraint minimisation, fire and emergency procedures, challenging behaviours, infection control, wound care, diabetes, informed consent, advocacy and Code of rights. Medication management training was provided in February 2011, scheduled for July 2012 but was not held and is again scheduled for September 2013. Improvements are required whereby medication education training is provided for staff.

On review of nine staff files, annual performance appraisals have been conducted and are up to date for six staff. The general manager and two other staff are overdue for their appraisals. Advised by the general manager that a system for conducting timely reviews is being implemented. Improvements are required in this area.

Annual competencies are completed for care staff and include restraint, insulin administration, medication and controlled drugs administration and wound care. Medication competencies are overdue for review in four of nine staff files reviewed and include the three clinical nurse managers and one care giver. Improvements are required in this area (link #1.3.12).

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication management and restraint minimisation. Not all RN's have completed annual competencies in medication management. (link #1.3.12). Two RN staff in the PG units are currently completing syringe driver training.

ARHSS D17.7 The diversional therapist working in the special care unit has completed ACE dementia modules.

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 15 care givers in the rest home dementia unit. Nine care givers have completed the required dementia standards, and six caregivers are in the process of completing.

ARHSS D17.1: There are 23 care givers working in the two psychogeriatric units - 19 care givers have completed the required dementia standards and four are in the process of completing.

Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Audit Evidence **Attainment:** PA **Risk level for PA/UA:** Low

Education provided in 2013 includes: oral health, challenging behaviours, infection control, fire and emergency procedures, IC reverse barrier nursing, cultural safety, and complaints management. Education completed in 2012 included safe moving and handling, dealing with complaints, abuse and neglect, communicating with people with dementia, restraint minimisation, fire and emergency procedures, challenging behaviours, infection control, wound care, diabetes, informed consent, advocacy and Code of rights. On review of nine staff files, annual performance appraisals have been conducted and are up to date for six staff. The general manager and two other staff are overdue for their appraisals. Advised by the general manager that a system for conducting timely reviews is being implemented.

Finding Statement

a) Medication management training has not been conducted since February 2011; b) Annual appraisals have not been conducted for all employees.

Corrective Action Required:
a) Provide education and training for staff around medication management; b) Ensure all employees have annual performance appraisals conducted.

Timeframe:
6 months

STANDARD 1.2.8 Service Provider Availability

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The annual leave and rostering policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the dementia unit and the two hospital psychogeriatric unit residents. There is at least one registered nurse rostered on at any one time. Registered nurses are rostered on 24/7 in the hospital units and provide after hours and week end cover to the dementia unit. The general manager is responsible for staff recruitment and for management of roster with support from three clinical nurse managers.

In the dementia unit the clinical nurse manager works Monday to Friday 9- 2pm. There are three caregivers rostered on in the morning, a laundry person and cleaner as well as diversional therapist 11.30 - 5.30pm. In the afternoon there are three caregivers and overnight there are two care givers rostered on.

In the two PG units there is a full time clinical nurse manager in each unit, three caregivers on in the morning, two in the afternoon and two over night. There are two RN's on in the afternoon and one on night shift who provide cover for both PG units and attend to the rest home dementia unit if and when required. The two PG units have designated laundry and cleaning staff. There are cooks and kitchen hands employed to cover every day of the week. Diversional therapist oversees all units and there are activity staff on over the week end. The service is currently recruiting for more activities staff to fully cover the PG units. Advised that due to a reduction in resident numbers, the DT hours have been adjusted accordingly.

Interviews with six caregivers (two dementia, four PG), 10 family members (three dementia and seven PG) identify that staffing is adequate to meet the needs of residents.

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being stored securely in the three unit nurses stations. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Archived documents are stored securely.

D7.1 Entries are legible, dates and signed by the relevant caregiver or RN including designation

Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.1 Entry To Services

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Resident's needs are assessed prior to entry by the psychiatric services for the elderly team of older person's health. The service has an admission policy, admission agreement, and resident/family/EPOA welcome pack which is given at entry. The information pack includes all relevant aspects of service and family/EPOA are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement

E3.1 Three of nine resident files (three dementia and six PG) were reviewed and all included a needs assessment as requiring specialist dementia care.

Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Evaluation methods used: D ☒ SI ☒ STI ☐ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

There is policy regarding acceptance and declining entry to service. Potential residents families are advised of decline of entry when there are no beds available, the general manager reports there have been no declined entry for any other reason. The service records the reason for declining service entry to residents and communicates this to family/whanau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice.

Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

There are policies and procedures that guide the admission of a resident and planning interventions with timeframes.

The clinical nurse managers complete the initial care plans, nine of the nine resident files reviewed (three dementia and six PG) this was completed on the day of admission, and are the principle RN's responsible for all assessment and care plan development. In the PG unit the registered nurses are allocated residents whom they are responsible for development of the care plan, with input by the caregivers and allied health. A suite of assessments are completed prior to the long term care plan being developed within three weeks (link #1.3.4). Family are involved from time of admission and continue to be involved when there is a review of the care plan. Communication with family is documented on the family contact sheet. A hand over sheet is used to document any issues and verbal handover occurs at the end of each shift by the RN. The attending GP assesses the resident within 48 hours of admission. Activity profiles and activities care plans have been completed by the senior diversional therapist.

D16.2, 3, 4: The nine files reviewed (six PG and three dementia rest home) identified that in all nine files an assessment was completed within 24 hours and seven files identify that the long term care plan was completed within three weeks (two files were for long term residents with first care plan archived). There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. All nine care plans evidenced evaluations completed at least four monthly but usually three, this included a new resident who had been in the unit three months.

D16.5e: Nine resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed if the GP has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools where completed in resident files on admission that included continence, falls risk, pressure area, nutrition, and pain. There was reassessment for identified areas at least six monthly, refer to 1.3.4.2.

ARHSS D16.6; Two residents with behaviours that challenge were reviewed from the psychogeriatric unit. Behaviour monitoring charts utilised included behaviour exhibited, interventions utilised and effectiveness. One resident had a behaviour assessment completed and reassessed. (link #1.3.4). All nine files reviewed the long term care plan and the DT plan included behaviour management strategies with all regularly evaluated by the clinical nurse manager or RN with responsibility for care plan development.

Tracer Methodology: Psychogeriatric level care.

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

Tracer Methodology: Dementia rest home level care.

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

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** PA Low

An initial assessment which also forms the initial care plan is completed by the admitting RN, which is usually a clinical nurse manager, within 24 hours of admission which includes a comprehensive range of possible needs.

Further detailed assessment tools are completed within three weeks of admission and completed at least six monthly including (but not limited to); continence, falls risk, pressure area and pain.

ARC E4.2; ARHSS D16.5gii Nine resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed if the clinical nurse manager identifies there is an issue.

Improvement is required to ensure reassessment of all possible care needs is documented.

Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Audit Evidence **Attainment:** PA **Risk level for PA/UA:** Low

There is a suite of assessment tools used on admission to assess the care needs of residents. There is a documented evaluation of the care plan completed at least four monthly but usually three monthly that includes reassessment of those areas that are identified by the RN as an issue or have a care need. On interview the three clinical nurse managers described considering all areas of possible care needs as they initially completed the long term care plan and when evaluated.

Finding Statement

Two of three dementia rest home and four of six PG files reviewed did not include a completed assessment tool for challenging behaviour on admission. Three of three dementia rest home and four of the six PG resident files reviewed did not include a documented assessment for challenging behaviour as a part of the evaluation process. Four of six PG resident files reviewed did not include routine reassessment of nutrition and or pain.

Corrective Action Required:
Ensure reassessment of all possible care needs is documented.

Timeframe:
3 months

STANDARD 1.3.5 Planning

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The clinical nurse managers are the principle RN's that develop the long term care plans with some residents allocated to the other RN's. The long term care plan includes pre-set prompts including goals to ensure a comprehensive range of possible care requirements are considered and addressed as required. Interview with four RN's (one RN and three clinical nurse managers) stated that all areas are considered. The long term care plan includes a section on behavioural management that compliments the behavioural section of the activities care plan.

E4.3 Three dementia specific resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, ARHSS 16.3g: Short term care plans are in use for changes in health status and were sighted for shortness of breath, wounds, and fragile skin.

D16.3f; ARHSS D16.5f Nine resident files reviewed identified that family were involved. Interview with 10 family members stated this was an area that the three clinical nurse managers ensured.

ARHSS 16.3g: Six of six PG resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All six PG residents' files included a section on behaviour management in both the long term care plan and the activity care plan.

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

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

Evaluation methods used: D ☒ SI ☒ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Nine resident files were reviewed that included care needs of:

PG unit residents: refer to 1.3.3.

Dementia Rest Home: refer to 1.3.3

D18.3 and 4 Dressing supplies are available in each of the three treatment rooms.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and access to this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for six residents.

The registered nurses interviewed described the referral process and related forms should they require assistance from a wound specialist or continence nurse.

ARHSS D16.4; There is good specialist input into residents in the PG unit via referral for psychiatric services for the elderly. Strategies for the provisions of a low stimulus environment could be described. The facility has a focus on reducing use of antipsychotic medicines.

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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

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.

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

Evaluation methods used: D ☒ SI ☒ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The facility is managed as three units - one dementia rest home and two psychogeriatric. Dedicated diversional therapy assistant hours are allocated to each psychogeriatric unit 1200 - 1700 seven days per week. Currently there are two activities assistant vacancies which the general manager advises are being actively recruited. One psychogeriatric unit currently has no dedicated DT position. However there are systems in place to ensure that activities occur while the position is being recruited. There is a qualified senior diversional therapist who works in the dementia rest home unit three afternoons per week and oversees the activities for PG units including dedicated hours on a Friday to complete the DT assessment, plan and review documentation.

There is planned group activities for the dementia unit and entertainers and outings weekly for all units including a wheelchair taxi to facilitate mobility impaired residents having outings. Outings are allocated on a rotational basis following consultation with the clinical nurse managers as to who are able to. In the dementia unit one-to-one activity of card games, cross-word and various other word games were observed. A van outing was undertaken in the afternoon.

Interview with the three clinical nurse managers, senior DT, and six caregivers described a focus on one-to-one activities carried out by the caregivers which includes talking, reading and walking. The general manager stated that there is a centralised music and DVD player for each unit, which was sighted, and caregiver staff carry out small group activities.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed regularly by the senior DT and the long term care plan includes behavioural management section written by the RN and this is reviewed as a part of the full care plan evaluation.

ARHSS 16.5g.iii: An activity profile which includes social history is completed by the senior DT following admission and information gathered is included in the activity care plan. Residents participation and expressed enjoyment is documented. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly but usually three monthly.

ARHSS 16.5g.iv: Caregivers were observed throughout the audit involved in providing one-to-one activity. There was no evidence of a resident requiring diverting from behaviours observed.

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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

D16.4a Care plans are evaluated at least four monthly but usually three monthly and more frequently when clinically indicated which was sighted on nine of nine resident files (three dementia and six PG) reviewed including two residents who had been admitted within the last six months. There is a new multi-disciplinary format being introduced with full implementation in the dementia rest home unit. This includes the residents clinical nurse manager, family, GP, DT and any others involved in the residents care. The house doctor for the dementia rest home complimented the multi-D as enhancing the relationship with the family and enabling full discussion of the resident's current health status. It was stated that the intent is to fully implement this format to the PG units.

There was evidence of changes to long term care plans as resident health status changes occurred.

The three clinical nurse managers described gathering information verbally and from progress notes from all staff to formulate the evaluation.

ARC: ARHSS D16.3c: All initial care plans were evaluated and developed into a long term care plan by a RN within three weeks of admission.

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The service facilitates access to other medical and non-medical services, evidenced by GP documentation, referral to psychiatric services of the elderly and involvement of visiting dietician. Referral forms and documentation are maintained on resident files.

There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent.

D16.4c; One resident file reviewed was for a resident of the dementia rest home transferred to the PG unit as health status deteriorated.

D 20.1 Discussions with four registered nurses identified that the service has access to all necessary resources including dietitian.

Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. There is a discharge or transfer of resident to another facility policy. The general manager reports there have been no declined resident for reason other than no vacant bed. One resident file reviewed was for a resident who was transferred from the dementia rest home to the PG unit.

Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** PA Moderate

The service uses the robotic medication packaging system and administration form. The medico Douglas prescribing chart is used. Eighteen of 18 medication charts reviewed were signed by the prescribing GP. as per good practice. Improvement is required to ensure all PRN, as required, medications include a documented indication of use.

The facility is run as three units with three treatment rooms that contain locked cabinets for storage of medication. In the two PG units a medication trolley is utilised for the administration of medication.

Medication administration in the PG units is carried out predominantly by the RN's but caregiver staff support administration if the RN is required for other duties and to countersign controlled drugs. In the dementia rest home caregiver staff completed medication administration. Administration was observed in all three units and correct process was followed. Medication training has been completed, improvement is required to ensure all staff who administer medications are assessed for competency at least annually.

Registered nurses are peer assessed for competency in administering medications. Caregivers responsible for administering medications are competency assessed by the clinical nurse manager of the unit they administer medications. Policy requires reassessment of all staff who administer medications, both RN and caregivers, to have an annual competency assessment. However, not all registered nurses and caregiver staff who administer medications have been had competency reassessed annually. This is also an area requiring improvement.

Controlled drugs are stored in a locked cabinet inside the medication cabinet in the locked treatment rooms of the two PG units. Controlled drugs required in the rest home are stored in the PG unit. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly by two RN's. Medication fridge temperatures are monitored monthly.

Not all PRN medications include a documented r\indication for use and this is an area requiring improvement.

No residents self-medicate.

D16.5.e.i.2; 18 Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Audit Evidence **Attainment:** PA **Risk level for PA/UA:** Moderate

The robotics medication packaging system is used with corresponding medication administration signing sheets. The medico Douglas prescribing chart is used to chart all medications to be administered by the resident GP. Both RN and competency assessed care giver staff administer medications across the three units. All routine medications were prescribed to good practice guidelines but 16 of the 18 medication charts reviewed not all of the PRN medication included an indication for use.

Finding Statement

Not all PRN medications prescribed included a documented indication of use.

Corrective Action Required:
Ensure all as required medications include a documented indication of use.

Timeframe:
1 month

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Audit Evidence **Attainment:** PA **Risk level for PA/UA:** Low

Registered Nurses are peer assessed for competency in administering medications. Caregivers responsible for administering medications are competency assessed by the clinical nurse manager of the unit they administer medications. Policy requires reassessment of all staff who administer medications, both RN and caregivers, to have an annual competency assessment.

Finding Statement

Not all registered nurses and caregiver staff who administer medications have been had competency reassessed annually.

Corrective Action Required:
Ensure all staff who administer medications are assessed for competency at least annually.

Timeframe:
3 months

Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

There is a central kitchen that prepares all food requirements for the facility. There is a rotational menu used that is reviewed by a dietitian. There is a food services manual that is comprehensive. A tour of the kitchen noted cleanliness and order in the pantry, fridges and freezer complying with guidelines. The residents have a dietary profile developed which identifies dietary requirements and likes and dislikes on admission which is copied to the kitchen with a summary that is readily available on the kitchen wall. Food is transported to the three dining rooms and heat maintained in bain maries until served. Caregivers are responsible for ensuring all food and fluids are at the required consistency for each resident. During observation of meal provision the senior caregivers were able to articulate how they gain knowledge of each residents food consistency and how it is ensured that this is meet.

Resident weights are monitored regularly and on the nine resident files reviewed weight was stable unless weight reduction was the aim. There was evidence of dietician input if there was a weight issue identified.

Each of the three units has a kitchenette where food can be reheated and snacks are available. Each has dish washing facilities with a steriliser.

E3.3f, ARHSS D15.2f: There is evidence that there is additional nutritious snacks available over 24 hours. Sandwiches are available at all times.

D19.2 Staff have been trained in safe food handling.

Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Evaluation methods used: D ☒ SI ☒ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. There is sluice facilities in each of the two laundries and separate sluice room in the PG unit that does not include a laundry. Chemicals are provided by Ecolab using their storage and dilution system, all are labelled and stored safely. There is appropriate personal protective equipment and clothing available for staff use. The non-cleaning chemical products and waste are stored on the adjacent section completely separate from the facility. There is an incident reporting system that includes investigation of all incidents including waste and hazardous chemical incidents.

Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

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

Evaluation methods used: D ☒ SI ☒ STI ☒ MI ☒ CI ☒ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met?	**Attainment:** PA Low

Legislation and regulatory requirements are met for local authorities and the MoH. Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The service displays a current warrant of fitness which expires on 5 March 2014. There

are maintenance policies and procedures in place including bi-annual electrical checks, evidence of which was sighted, and a comprehensive preventative maintenance schedule being implemented for 2013.

The facility is nearing completion of all earthquakes caused repair work with no current impact on the facility.

The facility is predominantly vinyl floor surfaces throughout including bathrooms/toilet with carpeted lounge areas for the dementia rest home. Hand rails are available around the hall ways. There is ample space for resident use including to safely mobilise using mobility aids with staff assistance in the wide hallways.

Bedrooms sighted included personal items particularly pictures and cards.

There is a transport policy with a facility van that has a current warrant of fitness and registration, drivers licences are checked.

There is separate staff and resident designated smoking areas.

Interviews with six caregivers and four registered nurses confirmed there was adequate equipment.

Interview with ten family members stated satisfaction with the facilities and care provided.

E3.4d, ARHSS D15.3d The three units have two lounge areas each that are designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; ARHSS D15.3e: The following equipment is available: electric beds, pressure relieving mattresses, shower chairs/stools, four hoists, heel protectors, movement support aids. Interviews with six caregivers confirmed there was adequate equipment.

E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required. Each of the three units has a main lounge dining area with one other lounge area and further seating in spaces in the hallways. The connecting hallway between the two PG units is security coded and provides a spacious area with seating which was described as available for family to meet separately with their resident.

E3.4.c; ARHSS D15.3b Each unit had access to two safe and secure outside areas which are well maintained with pathways, shade and seating.

Improvement is required to ensure all medical equipment and devices are calibrated according to manufacturer recommendations to ensure accuracy of recordings and function.

Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.

Audit Evidence **Attainment:** PA **Risk level for PA/UA:** Low

There is a comprehensive schedule for routine checks of the buildings, plant and equipment. The platform and chair weigh scale for monitoring resident weights were calibrated by an external service on the days of the audit.

Finding Statement

Not all medical equipment and devices had been calibrated to ensure accuracy of recordings and functions.

Corrective Action Required:
Ensure all medical equipment and devices are calibrated according to manufacturer recommendations to ensure accuracy of recordings and function.

Timeframe:
6 months

Criterion 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.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D ☒ SI ☒ STI ☒ MI ☐ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met?	**Attainment:** FA

All bedrooms in the two PG units have either shared or single ensuites. The dementia rest home has single and shared ensuites with six bedrooms using a communal facility of two shower toilet rooms and one other toilet. Shared ensuites do not have privacy lockage as the general manager stated no residents access the facilities independently and there is concern that residents, particularly in the PG units, may lock themselves in and become distressed due to being unable to call for assistance.

All facilities have signage. All communal toilets are in close proximity to service areas and readily accessible to residents.

There is five communal toilets and two staff only toilets throughout the three units that have a hand basin, soap dispenser, and paper towels in each. There is alcohol based hand rub dispensers throughout the facility. There is good signage throughout the facility regarding hand washing. Hot water temperature is monitored and recorded monthly. Flooring and fixture/fittings are designed to be easily cleaned and flooring is non-slip.

Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Evaluation methods used: D ☒ SI ☒ STI ☐ MI ☐ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Resident bedrooms are spacious to allow care to be provided and for the safe use and manoeuvring of mobility aids including hoists in the ensuites. Family interviewed are happy with their resident's rooms and report adequate space. Residents were observed moving freely around the facility and staff using mobile lounge chairs. Six caregivers interviewed report resident rooms have sufficient space to allow for the use of mobility equipment including ensuites. Personal items were noted.

Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D ☐ SI ☒ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Residents have access to a range of communal areas including a dining/ lounge and separate lounge area in each unit with a variety of seating types for the range of care needs provided. The areas are spacious allowing for staff access to residents if required. There are seating areas in the hallways and a secure large connecting hallway between the two PG units with seating which visitors can use with their resident if required.

Activities can occur in any of the lounge/ dining areas.

ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander including two outside areas for the dementia unit.

Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Evaluation methods used: D ☒ SI ☒ STI ☒ MI ☐ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

The service has in place policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness via the internal audit programme. There are two laundries, one for the dementia rest home and one for the two PG units. There is a designated area for the storage of cleaning and laundry chemicals in each laundry. The service ensures that the process for managing the flow of clean and dirty laundry is maintained through good laundry practice, clean and dirty entrances. There is personal protective equipment available to staff. The facility use Ecolab provided chemical systems with material safety data sheets available in the manuals. All storage areas that can be accessed in resident areas are key code locked.

Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.7 Essential, Emergency, And Security Systems

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The service has an emergency manual. There is currently a trained person with a first aid certificate on each shift. Rosewood rest home and hospital has a NZFS approved fire evacuation scheme, dated 7 November 2006. There are built in sprinkler systems, smoke and fire alarms throughout. A call bell light alerts staff to the area in which staff and residents require assistance. The rest home dementia unit has a main entrance where visitors and contractors must enter through two locked gates before signing in when entering the unit. Key pad locks to exit the service with signage reminding visitors not to allow residents external access for safety reasons. Access to each of the two hospital psychogeriatric units is via their own entrance - with key pad locks on the inside of the external doors. The units are also accessible to staff and management via external access door which links the dementia unit and the two PG units. There are two sets of locked key pad doors between the two PG units. Fire drill last conducted 27 June 2013. Civil defence kits are stocked and available - one for each unit and are checked monthly. Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. The service has a generator. Call bell system evident and in use for staff in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. Emergency manual includes fire and evacuation procedures, civil defence emergencies, a disaster plan including food and supplies, earthquake response, bomb threat, hold up, civil defence kits, resident and relative lists, and missing resident procedures. Registered nurses and some caregivers have current first aid and CPR certificates.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D ☐ SI ☒ STI ☐ MI ☐ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Rosewood is spacious, light, with heat pumps in each bedroom in the dementia rest home, heat pumps and under floor heating in other areas, with an ambient temperature that is maintained to ensure it is comfortable. Resident's rooms have access to natural light with external windows and there is adequate external light in communal areas. Smoking is only permitted in designated areas.

Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has two residents in unit two psychogeriatric unit assessed as requiring the use of restraint - one hospital resident with a lap belt and one resident with the option of either a lap belt or a pelvic harness. There are no enablers in use and no restraint in use in the dementia unit or PG unit one. The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. On-going consultation with the family/whanau is identified. Falls risk assessments are completed six monthly. Challenging behaviour assessments are completed as required. Policy dictates that enablers should be voluntary and the least restrictive option possible and the three clinical nurse managers, one registered nurse, six caregivers (two dementia, four PG) are familiar with this. The PG unit two clinical nurse manager is the service's restraint coordinator.

E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

ARHSS D16.6: There is a managing challenging behaviour policy. Staff received training around restraint minimisation and the management of challenging behaviours as part of compulsory education sessions. Challenging behaviour training conducted in May 2012 and March 2013. Restraint minimisation training conducted in April 2012 and competencies are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint.

Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

STANDARD 2.2.1 Restraint approval and processes

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinator (PG unit two clinical nurse manager) was able to describe the role and responsibilities. Approval for each form of restraint is reviewed at a frequency as determined by organisational restraint minimisation policy and resident safety. Two files were reviewed for two residents in PG unit two with restraint. The two restraint files relate to one resident with a lap belt and one resident with the option of either a lap belt or pelvic harness. No enablers and no restraint in the dementia unit or in PG unit one. Both files reviewed evidenced authorisation and consent forms completed appropriately. Restraint discussion is conducted at management meetings, and unit staff meetings. The restraint approval group meets twice a year (7 June 2013). Restraint use is reviewed at resident level as part of care plan review (or more often as needed).

Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.2 Assessment

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The restraint minimisation and safe practice policy outlines the service's approach to managing restraint. The policy includes the steps for assessment and use of restraint, role of the restraint coordinator, involvement of family and GP, risk assessment, the need to attempt to modify behaviour prior to the use of restraint, resident advance directives, previous tolerance of restraint application, resident medical and social history, cultural considerations, alternatives to restraint use and the goals of the restraint intervention. Two restraint files reviewed evidenced a documented and in-depth assessment had taken place which included the consideration of alternatives. Family/whanau input and consent is required prior to the application of any forms of restraint at Rosewood rest home and hospital.

Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

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

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.3 Safe Restraint Use

Services use restraint safely

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☒ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☒

How is achievement of this standard met or not met? **Attainment:** FA

Restraint policy states that the need for restraint use is monitored and reviewed as part of the three monthly care plan reviews. On review of two restraint files - this is well documented. Both residents have the option of restraint in place as both a prone to falls and attempt to mobilise quickly and unsafely if not assisted. All restraint when in use, is monitored at least half hourly and the residents is taken for regular walks and assisted to the toilet. Advised by the coordinator that the unit has actively worked at reducing the number of residents on restraint across the service. In 2012, PG unit one had three residents on restraint - in 2013, there are no residents on restraint. Monitoring signing sheets on the two files were reviewed. The service reviews all restraint use as part of the individual resident medical review, six monthly as part of restraint approval group meetings and at management and unit staff meetings. Restraint is only used at Rosewood as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. In PG unit two there is at least one staff member in the lounge at all times to supervise and monitor residents. Advised that both restraints currently in use is for safety measures to prevent falls. This is outlined as policy requirements in the restraint minimisation and safe practice policy. The policy requires that a restraint register is maintained with all residents' names and restraint details included. The restraint register is maintained and updated by the restraint coordinator (PG unit two clinical nurse manager) as required. Staff training records are maintained and individual participation in restraint training is identified. Restraint questionnaire and competencies are completed by all care staff and registered nurses.

Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.4 Evaluation

Services evaluate all episodes of restraint.

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The use of restraining devices is evaluated by the restraint coordinator (PG unit two clinical nurse manager) and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and GP. Points a) to k) below are considered as part of this review. On review of two files, two residents on restraint have been reviewed three monthly as per policy. Restraint use is discussed at the monthly management meetings, and six monthly restraint approval group meetings.

Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;

(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;

(f) The duration of the restraint episode and whether this was for the least amount of time required;

(g) The impact the restraint had on the consumer;

(h) Whether appropriate advocacy/support was provided or facilitated;

(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

(j) Whether the service's policies and procedures were followed;

(k) Any suggested changes or additions required to the restraint education for service providers.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

Rosewood rest home and hospital reviews the use of restraint as part of its internal audit processes (last audit 3 June 2013). The results of the restraint audit are discussed at the monthly management meetings, unit staff meetings and six monthly restraint approval group meeting. Any corrective actions identified are actioned through these forums. Policies and procedures are reviewed annually and updates are provided by the external quality consultant (10 March 2013). Education is provided at least two yearly and management of challenging behaviours education is provided annually.

Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

STANDARD 3.1 Infection control management

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

Rosewood rest home and hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. There is a monthly management meeting which includes health and safety and infection prevention and control. Discussion and reporting of infection control matters and consequent review of the programme occurs. Documented annual review of the programme was conducted in January 2013. The infection prevention and control objectives are contained within the quality plan for 2013. Infection rates and infection

prevention practices are discussed at each unit monthly staff meetings and minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. There have been no outbreaks since the previous audit.

Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The dementia unit clinical nurse manager at Rosewood is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending annual infection control updates. The IC nurse completed a graduate course in infection control in September 2012. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility.

Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

There is are infection control policy and procedures appropriate to for the size and complexity of the service.

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an external provider and reviewed and updated annually. Last review conducted July 2013. Rosewood's infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☒ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse attends training annually. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Education for staff is provided annually. This last occurred in June 2012 and May 2013.

Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Audit Evidence **Attainment:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 Surveillance

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

Evaluation methods used: D ☒ SI ☐ STI ☒ MI ☒ CI ☐ MaI ☐ V ☐ CQ ☐ SQ ☐ STQ ☐ Ma ☐ L ☐

How is achievement of this standard met or not met? **Attainment:** FA

Infection surveillance is an integral part of the infection control programme and is described in Rosewood's infection control surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly management meetings, and monthly unit staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical nurse managers, registered nurses, and general manager.

Criterion 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.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Audit Evidence	**Attainment:** FA	**Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe: