Village at The Park Care Limited

CURRENT STATUS: 11-Oct-13

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

GENERAL OVERVIEW

Village at the Park provides rest home, hospital and dementia level care for up to 89 residents. On the day of the audit, there were 80 residents (37 hospital, 32 dementia and 11 rest home).

There are well developed systems, processes, policies and procedures that are structured to provide appropriate care for people who use the service including residents that require hospital, rest home and dementia level care.

The improvements identified at the previous certification audit around some aspects of care planning and incident follow through, restraint assessment and restraint evaluation have been addressed. An improvement continues to be provided around pain assessments.

This audit identified that improvements are required around interventions and medication management.

AUDIT SUMMARY AS AT 11-OCT-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
	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

Indicator	Description	Definition
	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 11-Oct-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 11-Oct-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.		**Standards applicable to this service fully attained**

Continuum of Service Delivery	Day of Audit 11-Oct-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 11-Oct-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.		**Standards applicable to this service fully attained**

Restraint Minimisation and Safe Practice	Day of Audit 11-Oct-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 11-Oct-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**

Village at the Park

Village at the Park Limited

Surveillance audit - Audit Report

Audit Date: 11-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name	Village at the Park Limited

Premise Name	Street Address	Suburb	City
Village at the Park	130 Rintoul Street	Newtown	Wellington

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

Type of Audit	Surveillance audit and (*if applicable*)	
Date(s) of Audit	**Start Date:** 11-Oct-13	**End Date:** 11-Oct-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	XXXXXXXXX	RN, auditor certificate	12.00	6.00	10-Oct-13 to 11-Oct-13
Auditor 1	XXXXXXXXX	RN, auditor certificate	12.00	5.00	10-Oct-13 to 11-Oct-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXXX			1.00	

Total Audit Hours on site	24.00	**Total Audit Hours off site** *(system generated)*	12.00	**Total Audit Hours**	36.00
Staff Records Reviewed	10 of 68	**Client Records Reviewed** *(numeric)*	6 of 80	**Number of Client Records Reviewed using Tracer Methodology**	3 of 6
Staff Interviewed	15 of 68	**Management Interviewed** *(numeric)*	5 of 5	**Relatives Interviewed** *(numeric)*	6
Consumers Interviewed	7 of 80	**Number of Medication Records Reviewed**	12 of 80	**GP's Interviewed (aged residential care and residential disability)** *(numeric)*	1

Declaration

I, (full name of agent or employee of the company) XXXXXXXXX (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 Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 4 day of November 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
Village at the Park	89	80		☐	☒	☐	☐	☒	☐	☐	☒	☒	☐	☐	☐	☐

Executive Summary of Audit

General Overview

Village at the Park provides rest home, hospital and dementia level care for up to 89 residents. On the day of the audit, there were 80 residents, (37 hospital, 32 dementia and 11 rest home).

There are well developed systems, processes, policies and procedures that are structured to provide appropriate care for people who use the service including residents that require hospital, rest home and dementia level care.

The improvements identified at the previous certification audit around some aspects of care planning and incident follow through, restraint assessment and restraint evaluation have been addressed. An improvement continues to be provided around pain assessments.

This audit identified that improvements are required around interventions and medication management.

1.1 Consumer Rights

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with families including if an incident or care/medical issue arises.

The service has visiting arrangements that are suitable to residents and family. Complaints processes are implemented and complaints and concerns are managed and documented.

1.2 Organisational Management

The service has a well established strategic business plan and quality and risk management plan that continues to be implemented. Key components of the quality management system link to a number of meetings including staff and management meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and also to the Clinical Nurse Consultant and the CEO. The robust systems for quality and risk management are continually reviewed. The last policy review occurring April 2013. Benchmarking occurs with four other facilities owned by the Hurst Holdings Group. Results from audits and quality data have resulted in a number of quality improvements for both residents and staff. There is an active health and safety committee. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. Staff working in the dementia unit have completed NZQA education modules in dementia care. The staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff and resident input into rostering.

1.3 Continuum of Service Delivery

The registered nurses complete initial assessments and develop long term care plans within the required timeframes. Evaluations are completed by the registered nurses three monthly in the hospital unit and at least six monthly in the rest home and dementia units. The registered nurses sign care plans and evaluations completed by the enrolled nurses. Risk assessment tools are available. There is an improvement required around the use of pain assessment tools for residents with identified pain and current interventions.

Families and residents participate in the care planning process. Residents interviewed state their needs are being met. The Diversional therapist and activity co-ordinators provide an activities programme for the residents in the rest home, hospital and dementia care that meets the individual and group preferences. The Spark of Life Programme has been implemented.

There are policies and processes that describe medication management that align with accepted guidelines. Annual medication competency and education occurs for all medication competent persons. There is an improvement required in the assessment of self-medicating residents and dating of eye drops on opening. Medication charts meet the legislative prescribing requirements.

Meals are prepared on site. There is dietitian review of the menu and individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. There have been on-going improvements in food services.

1.4 Safe and Appropriate Environment

The Village in the Park building holds a current warrant of fitness. The interior and exterior buildings are well maintained. There are three ensuite bedrooms under construction due to be completed in the hospital wing in January 2014. There is access to necessary and essential equipment.

2 Restraint Minimisation and Safe Practice

Village at the Park has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. There are six residents with enablers (bedrail or lap belt) in use and five residents requiring the use of bed rails as a restraint and three residents requiring the use of a lap belt as a restraint. Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging. Review of restraint occurs three monthly and at six monthly restraint approval group meetings.

3. Infection Prevention and Control

The infection prevention and control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The infection control committee meets monthly. The service engages in benchmarking with other aged care facilities owned by Hurst Holdings Group.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	Not Applicable	0	0	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	Not Applicable	0	0	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	Not Applicable	0	0	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	Not Applicable	0	0	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	Not Applicable	0	0	0	0	0	2
Standard 1.1.7	Discrimination	Not Applicable	0	0	0	0	0	5
Standard 1.1.8	Good practice	Not Applicable	0	0	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	Not Applicable	0	0	0	0	0	9
Standard 1.1.11	Advocacy and support	Not Applicable	0	0	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	Not Applicable	0	0	0	0	0	2
Standard 1.1.13	Complaints management	FA	0	2	0	0	0	3

Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 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:4 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	Not Applicable	0	0	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	FA	0	2	0	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	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	Not Applicable	0	0	0	0	0	10

Organisational Management Standards (of 7): N/A:2 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 34): CI:0 FA:17 PA:0 UA:0 NA: 0

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	Not Applicable	0	0	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	Not Applicable	0	0	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	Not Applicable	0	0	0	0	0	5
Standard 1.3.5	Planning	Not Applicable	0	0	0	0	0	5
Standard 1.3.6	Service delivery / interventions	PA Moderate	0	0	1	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)	Not Applicable	0	0	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	Not Applicable	0	0	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:6 CI:0 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 2 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:11 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	Not Applicable	0	0	0	0	0	6
Standard 1.4.2	Facility specifications	FA	0	3	0	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	Not Applicable	0	0	0	0	0	5
Standard 1.4.4	Personal space/bed areas	Not Applicable	0	0	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining	Not Applicable	0	0	0	0	0	3
Standard 1.4.6	Cleaning and laundry services	Not Applicable	0	0	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	Not Applicable	0	0	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	Not Applicable	0	0	0	0	0	3

Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 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 36): CI:0 FA:3 PA:0 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	Not Applicable	0	0	0	0	0	3
Standard 2.2.2	Assessment	FA	0	1	0	0	0	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	0	6
Standard 2.2.4	Evaluation	FA	0	1	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6): N/A: 3 CI:0 FA: 3 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:3 PA:0 UA:0 NA: 0

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	Not Applicable	0	0	0	0	0	9
Standard 3.2	Implementing the infection control programme	Not Applicable	0	0	0	0	0	4
Standard 3.3	Policies and procedures	Not Applicable	0	0	0	0	0	3
Standard 3.4	Education	Not Applicable	0	0	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 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:2 PA:0 UA:0 NA: 0

Total Standards (of 50) **N/A:** 32 **CI:** 0 **FA:** 16 **PA Neg:** 0 **PA Low:** 0 **PA Mod:** 2 **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:** 40 **PA:** 3 **UA:** 0 **N/A:** 0

Corrective Action Requests (CAR) Report

Provider Name: Village at the Park Limited
Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:11-Oct-13 End Date: 11-Oct-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.3.6	1.3.6.1	PA Moderate	**Finding:** i) There is no short term care plan in place for a rest home resident with swallowing difficulties and a 2.4kg loss in one month; ii) Two of two rest home resident files sampled did not have pain assessments for identified pain. Two of two dementia care residents did not have pain assessments for identified pain. The outcomes of falls, continence and nutrition assessment is not reflected in the long term care plan for one dementia care resident; iii) There is no reference in the long term care plan of prophylactic antibiotics for two dementia level care residents. **Action:** Ensure identified changes to health status is reflected in the long term care plan. Ensure pain assessments are completed for residents with identified pain. This was a finding at previous audit and this remains an improvement.	1 month
1.3.12	1.3.12.1	PA Moderate	**Finding:** There are five eye drop bottles in use in the dementia care unit that have not been dated on opening. **Action**: Ensure eye drop bottles are labelled on opening.	1 month
1.3.12	1.3.12.5	PA Low	**Finding**: Two self-medicating residents in the rest hone have not had a self-medication assessment completed. **Action:** Ensure self-medication competencies are completed for all self-medicating residents.	1 month

Continuous Improvement (CI) Report

Provider Name:	Village at the Park Limited
Type of Audit:	Surveillance audit
Date(s) of Audit Report:	Start Date:11-Oct-13 End Date: 11-Oct-13
DAA:	Health and Disability Auditing New Zealand Limited
Lead Auditor:	XXXXXXXXX

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 1.1.9 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

Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. Registered nurses demonstrated their responsibility to notify family/whānau of any incident/accident that occurs. The general manager has an open-door policy.

D16.4b Six relatives (two hospital, two rest home and two dementia) stated that they are always informed when their family members health status changes. Access to interpreter services is identified, includes language support and access to the DHB.

Village at the Park has a multi-cultured staff and residents, registered nurses and caregivers described being able to interpret for some residents when needed.

Relatives interviewed (two hospital two rest home and two dementia) reported that that are made welcome when visiting and are able to visit any time.

Seven residents interviewed stated that family and friends are encouraged to visit. One relative interviewed stated she visited her mother and they often went over to the community centre for a coffee and a chat.

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.

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

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 1.1.13 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 general manager is responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated.

The complaints procedure is provided to resident/relatives at entry and also prominent around the facility on noticeboards. There is an electronic complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Discussion with seven residents and six relatives confirmed they were provided with information on complaints and complaints forms and one family member described having a concern addressed immediately. Complaint forms were visible to residents/relatives placed in various places around the facility. There is a complaints register. The complaints register for 2013 documented 10 complaints. These 10 complaints were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all identified resolution to the complainant's satisfaction. A letter dated 13-Jun-13 from the Coroner was sighted and stated the complaint was closed. Complaints education is provided as part of the code of rights/open disclosure training for staff and training sessions have occurred in February 2013.

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

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:

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

Village at the Park provides rest home, hospital and dementia level care for up to 89 residents. On the day of the audit, there were 80 residents, (37/39 hospital, 32/33 dementia and 11/17 rest home).

Village at the Park is part of the Hurst Holdings Group which owns four other aged care facilities in New Zealand.

Village at the Park has developed the philosophy " You matter because you are you and you matter to the last moment of your life. We will do all we can to help you, not only die peacefully but to live until you die". The organisation has a strategic direction that has been communicated to staff. The business plan denotes a client directed focus as the main driver. There is a business plan and annual quality and risk management plans 2013.

The CEO Aged Care Services reports directly to the Board of Directors. A Clinical Nurse Consultant (CNC) was appointed in July 2013 to support the GMs and staff at each facility and reports directly to the CEO. The GMs complete a monthly report to the CNC.

The general manager is a registered nurse. The general manager is supported by a clinical manager (dementia) care manager (hospital), an educator and two care coordinators. There are job descriptions for all positions that include responsibilities and accountabilities.

The Hurst Holdings Group provides a comprehensive orientation and training/support programme for their managers.

ARC,D17.3di (rest home), D17.4b (hospital), The general manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. The general manager attended the NZACA conference in August 2013.

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

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 1.2.3 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 quality and risk management system is implemented across each of the units with eight caregivers, three registered nurses and one enrolled nurse able to describe the quality system and how they learn from the information received each month.

There is an implemented audit schedule. Actions plans are documented where any audit scores less than 100%. Actions plans are signed off when achieved.

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. The facility have a copy of all policies & procedures with related forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. Last review occurred April 2013. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs at staff meetings. Release of updated or new policy/procedure/audit/education occurs across the facility (sighted). On discussion with the GM if an urgent change is required prior to a scheduled staff meeting a memo is sent out to each department identifying the document and a brief note regarding the specific change. This memo includes a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. The general manager requests that care managers of each department send a copy of the signed memo for filing. The CNC reviews policies and procedures which assures document control.

There are a range of meetings in place to ensure that staff are included and aware of the quality system. Meetings include monthly staff meetings at unit level, weekly management meetings, three monthly IC, cleaners meetings bi monthly and bi monthly H&S meetings. Meetings occurring monthly include; clinical meetings, administration staff meetings, activities, maintenance and grounds and monthly laundry and food service meetings.

The general manager provides a documented monthly report to Clinical Nurse Consultant (CNC) who reports to the CEO Aged Care at head office.

Benchmarking of health and safety and infection control statistics are generated monthly to review performance with other facilities in the group.

Customer satisfaction surveys are undertaken annually and results of the survey is documented as discussed in meetings.

D19.3:There is a comprehensive H&S and risk management programme in place. Village at the Park also has a health and safety committee that meets monthly and includes ten representatives from all areas of the facility.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk. The facility introduced the "falling star" initiative. This is where identification of those residents at risk of falls is highlighted by the use of a falling star symbol placed on their file. Falls prevention quality improvements implemented include GP prescribing of Vitamin D, assessment by the physiotherapist, three monthly clinical pharmacist review of medications to reduce the risk of medication interactions and poly-pharmacology, residents identified at risk wearing hip protectors, walks and exercise programme which includes Tai Chi exercise sessions. Falls are also included in the clinical indicator reports that are forwarded to the CNC, and analysed as part of the benchmarking programme within the Hurst Group.

Quality improvement projects which have been implemented include; All registered nurses have completed InterRAI training, purchase, introduction and implementation of the Spark of Life Programme in the dementia unit which includes a new service philosophy, a focus on person cantered care, a review of all policies and procedures which occurred in April 2013, the introduction of benchmarking across all Hurst Group facilities, resident involvement in the menu review process with the consultant dietitian, the introduction of a new food safety programme, a review of behaviour management to reduce the number of incidents of challenging behaviours occurring, the "falling star" initiative to alert staff of those residents who are a falls risk and the introduction of key workers for residents.

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:**

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:** FA

There is a documented incident process. Incident and accident forms are completed and all are reviewed by a registered nurse and aggregated trends fed back to the care managers and staff.

Discussion of incidents occurs at hand overs and staff meetings and this is documented on hand over sheets.

D19.3c: The service collects incident and accident data. There is a quality improvement initiative implemented related to falls as each residents who has been assessed as a falls risk has a "falling star" sticker placed on the outside of the residents file to alert staff.

Also the Vitamin D programme has been implemented with GPs prescribing Vitamin D (were appropriate) to assist with reducing the number of residents sustaining a fracture following a fall.

One of the quality objectives for 2013 is that the behaviour management programme has been reviewed and now requires staff to document Antecedent, Behaviour and Consequence of behaviour to resident/others. The impact on the management of falls related to be occurring from the behaviours of others will be evaluated at the end of the year.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required.

Twenty five incident forms for August 2013, Hospital were reviewed; There were eight falls, three controlled falls, eight skin tears, four bruises, one medication and one seizure. All incidents document that there is an RN follow up and review of incident. Five of the incidents were traced back to the care plans and progress notes. All reflected the incident and documented registered nurse assessment and contact with family/whanau.

Sixteen incident forms for August 2013 Dementia unit were reviewed: nine falls, one skin tear, three behavioural, one staff incident and one other (staff member did not complete room tidy and residents bed was unmade). Four incidents were traced back to the care plans and progress notes. All documented the incident, RN follow up and contact with family. Behavioural incidents were evidenced documented in resident files with follow up completed by a registered nurse. One fall evidenced follow up by the physiotherapist and review by GP post treatment for a UTI. STCPs were evidenced completed for skin tears.

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:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

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:** FA

There is an in-service education policy. Discussion with the general manager, two care managers, three registered nurses, eight caregivers, one education coordinator (RN) and one DT and two activity coordinators confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements.

There are fifteen annual compulsory education sessions which staff must attend. These are divided into blocks of three education sessions (study days) which are repeated six times annually and a varying times of the day to allow for easier staff access and better attendance. The ACE education programme is implemented and a training day is scheduled each week. Health Ed Honour Boards are displayed at reception with staff achievements. The registered and enrolled nurses attend external training. Eight of ten staff files sighted show that an annual performance appraisal has been completed that identifies specific training needs where these exist. Two staff have been recently employed and one had an appraisal completed three months following commencement of work. The other employee was employed in August 2013 and therefore three monthly assessment was not yet due.

All staff files sampled have evidence of appropriate employment practices including reference checks and police checks. Each file also contained a documented orientation. Practicing certificates were sighted for registered nurses, enrolled nurses, podiatrist, pharmacists, the physiotherapist and the GP's.

The facility has purchased the Spark of Life Programme which has been implemented in the dementia unit.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment. All registered nurses are completing competency level in PDRP with CCDHB.

E 4.5f - There are 14 staff working in the (dementia) unit. Nine staff have completed the required dementia standards, five caregivers are in the process of completing dementia standards and these five staff have commenced employment within the last six months.

There are 10 other staff members who have completed National Certificate in Support of the Older Person which includes the dementia unit standards. The GM advises that they utilise these staff members to cover for sickness and annual leave of dementia unit staff.

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:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

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 service provision policy aligns with contractual requirements and includes skill mixes. There is good registered nurse cover. Nursing/caring hours per resident day for the various client groups are documented.

The general manager works Mon-Friday 40 hours per week.

There are three units/departments within the facility. There is a care manager (RN) in the hospital who commenced employment with the service in May 2013 who works Monday-Friday 40 hours per week. The care manager has previous clinical management experience working in age care facilities.

The Educator (RN) works three days per week and spends one of those days in the rest home supporting the clinical coordinator who is an enrolled nurse.

There is a clinical coordinator (RN) on duty each weekend to support staff.

There have been changes made to the dementia unit roster since the previous audit which evidenced there was a care manager (RN) plus another RN or EN on duty in the dementia unit Monday-Friday on the morning shift. This has now changed and the clinical manager (RN) works Monday-Friday 40 hours per week in the dementia unit. Extra hours have been allocated to caregiver shifts and the ratio of staff to residents in the dementia unit is 1:4.

This has resulted in a reduction in the number of incidents of challenging behaviours. The incidents of challenging behaviours occurring in the dementia unit were 38% in January 2013 and with the change in staffing this has reduced to 13% in August 2013.

Family members from the dementia unit reported on interview that the change in staffing in the dementia unit is visible and that residents are occupied with activities or just sitting quietly with a member of staff having someone on one time. They also commented that the communication with family members has improved greatly since the clinical manager has been in charge of the dementia unit.

The service provides 24 hr RN cover. Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier.

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:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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

STANDARD 1.3.3 Service Provision Requirements

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

D16.2, 3, 4: The six files reviewed (two rest home, two hospital and two dementia), identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan is reviewed by a RN and amended when current health changes (link 1.3.6.1). All six care plans evidenced evaluations completed at least six monthly.

D16.5e: Six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly. A GP review stamp is used in the medical notes. The independent GP interviewed has been with the service for the last 7 years. The RN co-ordinates the three monthly resident reviews. The GP is available after hours and the weekends. Requests are phoned or faxed to the practice. Phone calls received for visits are appropriate and the RN assessment including observations have been completed prior to the calls/visits. The primary home GP conducts a weekly round of the residents enrolled in his practice. Three monthly resident reviews are completed as they fall due and residents of concern are examined at the weekly visit. The GP phones the family if they have been unable to attend the three monthly review. The primary GP is also available to be contacted on his mobile phone.

A range of assessment tools were completed in resident files on admission as appropriate and completed at least six monthly including (but not limited to); a) continence assessment and continence plan b) FRAT falls risk assessment c) Braden pressure area risk d) dietary requirements and nutritional risk assessment e) pain assessment (link 1.3.6.1) f) moving and handling assessment g) behaviour assessment h) wound assessment.

The physiotherapist visits weekly and completes moving and handling assessments on new admissions and follows up any RN resident concerns. Referrals are initiated by the RN or GP. The podiatrist visits three weekly.

The psychogeriatric nurse (PN) visits the dementia care unit monthly and as required in consultation with the clinical manager. The PN liaises closely with the Psychogeriatrician. Any dementia care residents requiring re-assessment to higher level of care are admitted to Kenepuru assessment unit. Mary Potter Hospice provide support and resources for palliative care residents. The service uses the Liverpool care pathway (LCP). A post LCP implementation audit has been completed with positive results.

Seven caregivers interviewed (three dementia, three hospital, one rest home), one enrolled nurse and three registered nurses described the handover procedure at the change of shifts.

Tracer Methodology: Dementia care unit resident

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

Tracer Methodology: Hospital level resident

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

Tracer Methodology: Rest home resident

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 1.3.6 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:** PA Moderate

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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 this could be described. One of the RN's is a continence resource person. The hospital clinical manager was a previous USL Continence representative. Continence management in-services have been provided.

Wound assessment, dressing treatment plan, wound progress and evaluation notes are in place for one dementia care resident with a chronic wound, two rest home residents with chronic wounds (on admission) and one hospital resident with a chronic wound. Photographs show evidence of wound healing. District Nurses have been involved in two of the chronic wounds. Short term care plans are used for skin tears. One resident with a chronic wound and is on protein drinks to aid healing.

Residents with falls are assessed by the physiotherapist as required. The physiotherapist reviews residents in the dementia care unit as needed. Most of the residents in dementia care unit have sensor mats in place on the floor by their beds at night. The Occupational Therapist can be accessed if required regarding equipment.

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:** PA **Risk level for PA/UA:** Moderate

i) The dietitian visits monthly and the Nutrition Nurse follows up on at risk residents. Residents are weighed monthly. The chair scales are calibrated annually.

ii) Pain assessments are completed in two of two hospital resident files. Assessments are reviewed at least six monthly or earlier for new or acute pain.

iii) Short term care plans are in place for resident infections. There is evidence of evaluations of infections.

Finding Statement

i) There is no short term care plan in place for a rest home resident with swallowing difficulties and a 2.4kg loss in one month; ii) Two of two rest home resident files sampled did not have pain assessments for identified pain. Two of two dementia care residents did not pain assessments for identified pain. The outcomes of falls, continence and nutrition assessment is not reflected in the long term care plan for one dementia care resident; iii) There is no reference in the long term care plan of prophylactic antibiotics for two dementia level care residents.

Corrective Action Required:
Ensure identified changes to health status is reflected in the long term care plan. Ensure pain assessments are completed for residents with identified pain. This was a finding at previous audit and this remains an improvement.

Timeframe:
1 month

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 qualified diversional therapist (DT) and three activity co-ordinators provide an activity programme for each of the areas, rest home, hospital and dementia care residents that meet the individual physical and cognitive abilities. There is a new activity co-ordinator currently being orientated. The DT attends the regional support group and receives peer support from other DT's. There are plans for the DT to attend conference next year. The activities team attend on site in-service relevant to their role. Planning the activity programme occurs at the regular DT team meetings. There have been quality initiatives implemented such as The Spark of Life Programme, "The Club" programme and setting up "do you remember" boxes. The Club programme includes games, films, music, gardening, men's club (includes pool), speakers corner, coffee mornings, women's club and art club. There is one on one time for those residents unable to participate or who choose not to take part in group activities. Residents are encouraged to maintain their links with the community and transport is arranged as required. There is a company van available for shopping trips and outings and a wheelchair mobility van is hired for outings as required. Anglican and Catholic church services are held in the hospital and open to residents from the other units. There is a chapel within the facility. A social history and activities care plan is completed for every resident on admission. The activity co-ordinators are involved in the three monthly multidisciplinary reviews. Feedback on the activity programme is received through the resident meeting, annual activity audit, family survey and verbal feedback. Goals for the future include integrating the programme and having several programmes running at the same time. The resource cupboard will be moved to a central area for all units to be able to readily access. Residents interviewed (four rest home and three hospital) and relatives interviewed (two rest home, two hospital and two dementia care are satisfied with the variety of activities offered. The residents enjoy the entertainers and outings provided.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

The RN evaluates the long term care plans three monthly in the hospital unit or earlier if there are health changes. The long term care plans are evaluated at least six monthly in the rest home and dementia care unit. The RN countersigns the enrolled nurse reviews of care plans in the rest home. Short term care plans are used for short term/acute needs (link 1.3.6.1). The short term care plans are evaluated regularly with ongoing needs transferred to the long term care plan. Three monthly resident reviews occur in consultation with the GP/RN and resident/family.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated

D16.3c: All initial care plans were evaluated by the RN/EN 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 1.3.12 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

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals and the robotic rolls. The registered nurse (RN) on duty checks incoming medications and resident admission/transfer medications. A reconciliation medication book is maintained. Any discrepancies are fed back to the pharmacy. RN's and senior caregivers who administer medications undergo an initial competency and two weeks medication supervision with an RN. Annual medication competencies are completed and medication education is attended. A medication persons signature list is current. RN's attend Mary Potter hospice for syringe driver training and annual refreshers. Medication trolleys are kept in locked areas in the rest home, dementia care and hospital units. The hospital unit has two controlled drug safes that holds the facility controlled drugs for each area. There are weekly controlled drugs checks and six monthly pharmacy audits. There are weekly checks of all prn medications. There are current standing orders in place for use in the hospital unit only. Verbal orders received from the GP's are faxed to the RN and are signed on the medication chart within seven days. Medication fridges are monitored and the temperatures are within the acceptable range.

Medication charts sampled (four rest home, four hospital and four dementia care) have photo identification and allergies/adverse reactions documented. PRN medications are prescribed with the indication for use. Medication administration signing sheets are correct. Controlled drugs are signed by two staff on the medication administration form. There are special instructions regarding resident medications and crushing of medications.

D16.5.e.i.2; 12 medication charts reviewed (four rest home, four hospital and four dementia care) identified that the GP had seen the reviewed the resident 3 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

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals and the robotic rolls. The registered nurse (RN) on duty checks incoming medications and resident admission/transfer medications. A reconciliation medication book is maintained. Medication charts sampled (four rest home, four hospital and four dementia care) have photo identification and allergies/adverse reactions documented. PRN medications are prescribed with the indication for use. Medication administration signing sheets are correct. Controlled drugs are signed by two staff on the medication administration form. There are special instructions regarding resident medications and crushing of medications.

Finding Statement

There are five eye drop bottles in use in the dementia care unit that have not been dated on opening.

Corrective Action Required:

Ensure eye drop bottles are labelled on opening.

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:** FA **Risk level for PA/UA:**

Finding Statement

Corrective Action Required:

Timeframe:

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

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

There is a self-medication policy and competency assessment. There are two self-medicating residents in the rest home area. There is medication administration monitoring of the self-medicating residents.

Finding Statement

Two self-medicating residents in the rest hone have not had a self-medication assessment completed.

Corrective Action Required:
Ensure self-medication competencies are completed for all self-medicating residents.

Timeframe:
1 month

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

The qualified cooks and kitchen hands prepare and cook all meals on site including morning and afternoon teas. There is a five weekly menu in place which has been reviewed by the dietitian. The main meal is in the evening. The cook receives a dietary requirement form for each new resident and is notified of any changes to resident requirements. Resident likes, dislikes and special diets are accommodated such as gluten free, vegetarian and high protein. Normal, soft and purred meals are provided according to RN assessment. Diabetic desserts, ice cream and jams are provided for diabetic residents. The main meal has an alternative choice offered. The meals are delivered to the areas in hot boxes and served from bain maries. Hot food is monitored on completion of cooking and prior to serving from the bain maires. The food services liaise with the activities team regarding resident birthdays, theme days and happy hours. The dementia unit has a "snack box" that contains nutritious snacks and foods and is refilled every day. Chilled and frozen foods have the temperature checked on delivery and prior to storage. Fridge, freezer and chiller temperatures are checked twice daily. All fridges in the facility have temperatures monitored daily. The kitchen is spacious with entry and exit entrances, dishwashing area and separate storage, cooking and baking areas. Chemicals are stored in a locked room. Ecolab monitor chemical use, provide safety data sheets and training as required. Staff have attended chemical safety training, first aid and food safety education. The cook attends the residents meeting for feedback on the service and menu suggestions. The food services have monthly meetings. Four rest home and three hospital residents interviewed stated they are happy with the food service and choices offered. There have been ongoing improvements with resident involvement.

E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours

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 1.4.2 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:** FA

The facility has a current building warrant of fitness that expires 23 March 2014. The fire evacuation letter of approval is dated 14 May 2004.

A letter from Ministry of Health dated 07-Oct-13 requested that the auditors include specific reference to the progress of the completion of a proposed additional three beds. There are currently three executive ensuite bedrooms under construction off the hospital wing. The corridor off the hospital lounge has been closed off and the large dining room is currently being utilised as a lounge/dining room. Two residents with their bedrooms in close proximity to the construction area have been moved in the interim and those rooms are not in use. A fire wall is being installed between the communal area and the bedrooms. Staff interviewed stated there has been minimal disruption to the service. The GM advises that the building project is estimated to be completed in January 2014.

Hot water temperatures in resident areas are monitored monthly.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities. There are several smaller seating and alcove areas.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower trolley, shower chairs, hoists, heel protectors, lifting aids, mobility aids, sensor mats, wheelchairs, hi low beds, electric beds, chair scales.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access.

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

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

Finding Statement

Corrective Action Required:

Timeframe:

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:

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 is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

The process of assessment and evaluation of enabler use is included in the policy. Currently the service has five residents on the register with an enabler in the form of bedrails and one resident who has a bedrail and lap belt as an enabler. The files reviewed of three residents identified as having an enabler in the form of a bedrail included an enabler assessment. The service currently has five residents requiring a bedrail that has been assessed as a restraint and three residents assessed as requiring the use of a lap belt as a restraint.

There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

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 behaviours,

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 2.2.2 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 previous certification audit identified that assessments did not identify the risks of using a restraint. This audit found that a restraint assessment form is completed for those residents requiring restraint. Five restraint files were reviewed. All included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly (written evaluation sighted) therefore this finding has been addressed.

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 2.2.4 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 previous certification audit identified that the restraint evaluation did not meet the criteria required to meet the standard and that family involvement in the evaluation process was not documented. This audit evidenced that the restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred three monthly as part of the on-going reassessment for the residents on the restraint register, and as part of care plan review. Families are included as part of this review. A review of five files identified that evaluations are up to date and have been reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed also six monthly through restraint approval group review meetings. Evaluation timeframes are determined by risk levels, therefore this finding has been addressed.

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:

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

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

The infection control policy includes a surveillance policy. The surveillance policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management.

Infections are included on a monthly register and a monthly report is completed by the infection prevention and control officer.

Infection control data is collated monthly and is documented as discussed at the various service meetings. The infection control programme is linked with the quality management programme.

There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There is an outbreak of influenza documented as occurring in July 2012. DHB were notified of the outbreak and outbreak management plan includes the infection control measures implemented and processes followed including communication with residents, staff, family/whanau and DHB IC nurse specialist. Archived STCPs were sighted for respiratory illness/flu with care interventions documented.

There are three residents with a diagnosis of MRSA +ve. Caregivers interviewed who work in the hospital unit (3) were able to describe the infection control measures implemented. Care plans reviewed document the infections and infection control measures that are in place. There are two residents in the dementia unit who are prescribed prophylactic antibiotics, however the care plans reviewed do not document the use of prophylactic antibiotics. (link to 1.3.6.1)

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: