St John's Parish (Roslyn) Friends of the Aged and Needy Society

Current Status: 22 November 2013

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

General overview

Leslie Groves Residential Care Facility is a not for profit residential service governed by St John's Roslyn, Anglican Church. The service is certified for hospital, medical, and rest home services. Leslie Groves operates over two sites - the hospital situated at Waikari and the rest home in Roslyn, Dunedin.

The service continues to be managed by an experienced nurse manager who reports to the board of the St John's (Roslyn) Friends of the Aged And Needy Society Inc.

Leslie Groves is undergoing staged re-development of the Waikari hospital facility. The staged re-development programme has been underway since 2011 across the facility. This verification audit was in regards to reviewing; (i) seven current hospital rooms to be included as part of the dementia unit. This increases the current 10 bed dementia unit to 17 beds. (ii) Verifying the new 23 bed psychogeriatric unit. This unit includes 11 older rooms (re furbished) and 12 newly-built rooms, lounge and dining area.

With the completion of the changes, upgrades and re-build there will be a 31 bed hospital unit, 17 bed dementia unit, and 23 bed psychogeriatric unit, making a total of 71 beds. A re-development risk management plan has been developed and implemented.

There are improvements required related to the completion of the building and approval of the fire evacuation scheme.

HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	St John's Parish (Roslyn) Friends of the Aged and Needy Society
Certificate name:	Leslie Groves Hospital

Designated Auditing Agency:	HDANZ

Types of audit:	Verification
Premises audited:	Leslie Groves Hospital, 321 Taeiri Road, Halfway Bush, Dunedin
Services audited:	Psychogeriatric, dementia
Dates of audit:	**Start date:** 22 November 2013 **End date:** 22 November 2013

Proposed changes to current services (if any):
This verification audit was in regards to reviewing two updated to the service. (i) To review seven current hospital rooms to be included as part of the dementia unit. This will increase the current 10 bed dementia unit to 17 beds. (ii) Verifying the 23 bed psychogeriatric (PG) unit. This unit includes 11 older rooms (re furbished) and 12 newly-built rooms, lounge and dining area.

Total beds occupied across all premises included in the audit on the first day of the audit:	52

Audit Team

Lead Auditor	XXXXX	**Hours on site**	3	**Hours off site**	2
Other Auditors		**Total hours on site**		**Total hours off site**	
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	.5

Sample Totals

Total audit hours on site	3	Total audit hours off site	2.5	Total audit hours	5.5

Number of residents interviewed		Number of staff interviewed	1	Number of managers interviewed	1
Number of residents' records reviewed		Number of staff records reviewed		Total number of managers (headcount)	2
Number of medication records reviewed		Total number of staff (headcount)	63	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

I, XXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Tuesday, 3 December 2013

Executive Summary of Audit

General Overview
Leslie Groves Residential Care Facility is a not for profit residential service governed by St John's Roslyn, Anglican Church. The service is certified for hospital, medical, and rest home services. Leslie Groves operates over two sites - the hospital situated at Waikari and the rest home in Roslyn, Dunedin. The service continues to be managed by an experienced principal nurse manager who reports to the board of the St John's (Roslyn) Friends of the Aged And Needy Society Inc. Leslie Groves is undergoing staged re-development of the Waikari hospital facility. The staged re-development programme has been underway since 2011 across the facility. This verification audit was in regards to reviewing; (i) seven current hospital rooms to be included as part of the dementia unit. This increases the current 10 bed dementia unit to 17 beds. (ii) Verifying the new 23 bed psychogeriatric (PG) unit. This unit includes 11 older rooms (re furbished) and 12 newly-built rooms, lounge and dining area. With the completion of the changes, upgrades and re-build there will be a 31 bed hospital unit, 17 bed dementia unit, and 23 bed psychogeriatric unit (PG), making a total of 71 beds. A re-development risk management plan has been developed and implemented. There are improvements required related to the completion of the building and approval of the fire evacuation scheme.

Outcome 1.1: Consumer Rights

Outcome 1.2: Organisational Management
The principal nurse manager (PNM) completes a monthly report for the Board. There is a OpQual Plan for 2010-2013 that outlines key performance areas such as: ensure services are relevant to identified resident needs; resident/family involvement in care; palliative care services; dementia services; medications management; human resources which includes but is not limited to orientation, education performance appraisal and recruitment. The plan includes staff responsible, achievement measures and timeframes for completion. The staged re-development programme has been underway since 2011 across the facility. The service has completed verifications of these stages February and September 2013. A draft roster has been developed for staffing the 17 bed dementia unit. Diversional therapy hours will be included as a minimum of three hours per day with an increase to seven days a week. Registered nurse cover will be provided from adjoining PG or hospital units and by the Quality Coordinator (RN). The roster for the PG unit remains unchnged and includes a registered nurse (RN) across all shifts and a unit manager.

Outcome 1.3: Continuum of Service Delivery
There are no changes to the kitchen/food service since previous audit. Ace Foods contractors have the food provision contract for Leslie Groves. A large purpose built kitchen is located on the ground floor. Ace Foods has policies/procedures for food services and menu planning appropriate for the services. The dementia unit and PG unit both have open planned dining and

kitchenettes. Hot water is kept behind locked cupboards. Food is transported to each unit via hot boxes. The dining rooms are large enough for the increase of residents in the dementia unit and in the new PG unit.

Outcome 1.4: Safe and Appropriate Environment

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and there is appropriate protective equipment and clothing for staff including gloves, gowns and eye protection. There is a sluice room available in the PG unit.
The service has a current building warrant of fitness, a certificate for public use for the previously opened areas and regular maintenance is carried out. As part of a staged re-development, older parts of the facility have been altered. The PG unit is not yet completed and therefore the certificate for public use has not yet been signed off
Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. There is sufficient room throughout the service for residents to mobilise safely. Floor surfaces are appropriate and equipment is obtained as identified.
There are quiet, low stimulus areas that provide privacy when required in both units.
There is a safe and secure outside area that is easy to access. Access to a secure courtyard is currently available for the PG and the dementia residents
There are full ensuites or shared ensuite facilities for both wings. The two units are spacious and allow movement for residents, staff and any mobility equipment.
The dementia unit has two lounge areas and a dining area with kitchenette facilities. The PG unit has a centrally located combined lounge/dining area. Residents are able to access areas for privacy if required.
The service has in place policies and procedures for effective management of laundry and cleaning. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures.
There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The fire evacuation scheme is in draft and will be approved following completion of the building. Emergency training is included in the orientation. Fire drills are conducted six monthly. A call bell system has been installed in the PG unit; however, this is not yet fully functional.
General living areas include individualised panel wall heating in each bedroom, a ceiling heat pump in the dining/lounge area and radiator heating in the hallways. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

Outcome 2: Restraint Minimisation and Safe Practice

Outcome 3: Infection Prevention and Control

There are policies and procedures in place relating to Infection prevention and control that support Infection Control Standard. There is a designated infection control nurse who reports to the management team. Infection prevention and control is part of the risk management plan developed for the staged rebuild of the facility.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	10	0	2	0	0	0
Criteria	0	21	0	3	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	38
Criteria	0	0	0	0	0	0	0	77

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	The PG unit is not yet completed and therefore the certificate for public use has not yet been signed off	A Certificate of Public Use (CPU) must be sighted by DHB/healthcert prior to opening of the unit	Prior to occupancy
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.3	Where required by legislation there is an approved evacuation plan.	PA Low	The fire evacuation scheme is in draft and will be approved following completion of the building	Ensure the fire evacuation scheme has been approved by the fire service	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Low	A call bell system has been installed in the PG unit, however, this is not yet fully functional	Ensure that the call bell system is fully functional.	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Leslie Groves is managed by a principal nurse manager (PNM) who is a registered nurse (RN) with a MA Nursing. She has varied experience within the health sector including 17 years within the aged care sector and 10 years as manager of Leslie Groves. The PNM is supported by a quality manager (RN), a clinical team leader (RN) who is based in the Redfern (hospital) unit and a unit manager who is based in Taieri unit (psychogeriatric). The rest home is based at a different location and has a nurse unit manager on site who reports to the PNM.
The principal nurse manager (PNM) completes a monthly report for the Board (who meet monthly) and includes (but is not limited to) reporting on quality issues such as incidents and complaints, and financial performance. There is a OpQual Plan for 2010-2013 that outlines key performance areas such as: ensure services are relevant to identified resident needs; resident/family involvement in care; palliative care services; dementia services; medications management; human resources which includes but is not limited to orientation, education performance appraisal and recruitment. The plan includes staff responsible, achievement measures and timeframes for completion.

The staged re-development programme has been underway since 2011 across the facility. The service has completed verifications of these stages Feb 13 and Sept 13.
This verification audit was in regards to reviewing two updates/changes to the service. (i) to review seven current hospital rooms to be included as part of the dementia unit. Increasing the current 10 bed dementia unit to 17 beds. (ii) Verifying the 23 bed psychogeriatric (PG) unit . This unit includes 11 older rooms (re furbished) and 12 newly-built rooms, lounge and dining area.

With the completion of the changes, upgrades and re-build there will be a 31 bed hospital unit, 17 bed dementia unit, and 23 bed psychogeriatric unit (PG), making a total of 71 beds.

On the day of audit there are hospital residents (21), psychogeriatric residents (23) and eight dementia residents. The rest home facility is located at 22 Sheen Street, Roslyn, Dunedin and was not included as part of this verification. (Leslie Groves Home).

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)
The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)
The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)
Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

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

Attainment and Risk: FA
Evidence:
There is an implemented staffing policy in place and includes workload analysis, staffing levels and skill mixes. Policy last reviewed 13-Aug-2013. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Numbers defined (based on occupancy) - can

be increased/decreased based on same. Levels are reviewed at least annually.

A draft roster has been developed for staffing the 17 bed dementia unit. Advised that with full occupancy there would be two staff in the am shift, two staff in the pm and one caregiver overnight. The morning and afternoon shift would include an enrolled nurse and/or caregiver.
Diversional therapy hours will be included as a minimum of three hours per day with an increase to seven days a week. Registered nurse (RN) cover will be provided from adjoining PG or hospital units and by the Quality Coordinator (RN).

The roster for the PG unit remains unchanged and includes a registered nurse (RN) 24/7.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

There are no changes to the kitchen/food service since previous audit.
External contractors have the food provision contract for Leslie Groves. A large purpose built kitchen is located on the ground floor. Ace Foods has

policies/procedures for food services and menu planning appropriate for the services. Winter and summer menus are created by a registered dietitian. There is a kitchen manual which contains policies and procedures related to cleaning equipment used in the kitchen and the kitchen itself, food handling, and preparation, personal hygiene in the kitchen, nutritional plan, quality aims, checking of temperatures, food storage, kitchen access, routines. A dietary assessment is made by the RN as part of the assessment process. There was evidence of residents receiving supplements. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers is covered and dated. ACE food services conduct audits as part of their own food safety programme. Special or modified diets are catered for (sited in PG unit). Advised that resident's food preferences are identified on admission. This includes consideration of any particular dietary needs (including cultural needs). Each resident has a dietary assessment that provides information on dietary needs and preferences. Each resident has a menu sheet that ensures the correct meals are delivered. Soft and puree dietary needs are documented.
Leslie Grove conducts audits including: a) fridge and freezer temperature recordings; b) annual resident survey; Food and meals are agenda items at the resident meetings.
The dementia unit and PG unit both have open planned dining and kitchenettes. Hot water is kept behind locked cupboards. Food is transported to each unit via hot boxes. The dining rooms are large enough for the increase of residents in the dementia unit and in the new PG unit.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

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

Attainment and Risk: FA
Evidence: The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has a system for investigating, recording, and reporting spills of biological material, blood/body substance exposures, and for managing waste. Safe storage of cleaning chemicals was evident in the both areas. Chemicals are labelled and there is appropriate protective equipment and clothing for staff including gloves, gowns and eye protection. There is a sluice room available in the PG unit.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Low

Evidence:

The service has a current building warrant of fitness, a certificate for public use for the previously opened areas and regular maintenance is carried out. As part of a staged re-development, older parts of the facility have been altered. This verification audit was in regards to reviewing two updates to the service. (i) To review seven current hospital rooms to be included as part of the dementia unit. This will increase the current 10 bed dementia unit to 17 beds. (ii) Verifying the new 23 bed psychogeriatric (PG) unit. This unit includes 11 older/existing rooms (re furbished) and 12 newly-built rooms, lounge and dining area. A CPU is to be obtained for the new area on completion.

Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. There is sufficient room throughout the service for residents to mobilise safely. Floor surfaces are appropriate and equipment is obtained as identified

E3.4d, ARHSS D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities in both the dementia and PG unit.

ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required in both units.

E3.4.c; ARHSS D15.3b There is a safe and secure outside area that is easy to access. Access to a secure courtyard is currently available for the PG and the dementia residents.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The service has a current building warrant of fitness, a certificate for public use for the previously updated areas has been obtained and regular maintenance is completed. In the previous certification they were required to ensure all dementia areas are secure. This is in place. This verification audit was in regards to reviewing two updated to the service. (i) To review seven current hospital rooms to be included as part of the dementia unit. Increasing the current 10 bed dementia unit to 17 beds. (ii) Verifying the new 23 bed psychogeriatric (PG) unit. This unit includes 11 older rooms (re furbished) and 12 newly-built rooms, lounge and dining area. Hot water temperatures are being monitored in all areas and are below 45 degrees. The building requirements identified for completion in the September verification audit have been addressed.

There is a key padded secure entrance to each area.

Finding:

The PG unit is not yet completed and therefore the certificate for public use has not yet been signed off

Corrective Action: A Certificate of Public Use (CPU) must be sighted by DHB/healthcert prior to opening of the unit
Timeframe (days): Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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

Attainment and Risk: FA
Evidence: There are full ensuites or shared ensuite facilities for both wings. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment in ensuite bathroom facilities. These facilities are appropriate for the client group and allow for mobility equipment. The lounge/dining rooms are central in both units and advised that residents would go back to their ensuites to use toilets.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

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

Attainment and Risk: FA
Evidence: Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents in a hospital stretcher is achievable if necessary and equipment can be transferred between rooms. The two units are spacious and allow movement for residents, staff and any mobility equipment.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

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

Attainment and Risk: FA
Evidence:
The dementia unit has two lounge areas and a dining area with kitchenette facilities. The PG unit has a centrally located combined lounge/dining area. Residents are able to access areas for privacy if required. Furniture has been chosen and is appropriate to the setting and will be arranged to enable residents to mobilise. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

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

Attainment and Risk: FA
Evidence:
Finding:

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

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

Attainment and Risk: FA
Evidence: The service has in place policies and procedures for effective management of laundry and cleaning. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry audit and cleaning audits are completed as per internal audit schedule. Laundry chemicals are stored securely in the laundry which is located in the basement. There is a locked cleaning cupboard in the units to provide safe secure storage.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

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

Attainment and Risk: FA
Evidence:

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

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

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

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

Attainment and Risk: PA Low
Evidence: D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency readiness plan includes fire policy and instructions, emergency plans, bomb threat, earthquake, prowlers and intruders, and civil defence emergencies. Emergency training is included in the orientation. Fire drills are conducted six monthly. The fire evacuation scheme is in draft and will be approved following completion of the building. The facility maintains civil defence packs and emergency lighting, alternative energy, gas barbeque and bottled gas, water supply, blankets and bulk food for three days stored. There is a generator available. There are contingency plans for back up supplies. Water tanks are available. Emergency lighting and cooking is available in the event of a power failure. The call bells system is functional in all areas currently occupied. The call system is not yet operational in the PG unit. There are call bells available in the dining and lounge rooms and bathrooms. Visitor and contractors sign in is required. There is a security policy. The service secures the buildings at nightfall. Training in fire safety and drills have been undertaken by staff. Fire alarms, sprinkler system, smoke detectors and fire doors in place in each area and approved as part of the CPU (link 1.4.2.1 for the PG unit).

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

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

Attainment and Risk: FA
Evidence:
Finding:

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

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: PA Low
Evidence: Emergency training is included in the orientation. Fire drills are conducted six monthly.
Finding: The fire evacuation scheme is in draft and will be approved following completion of the building
Corrective Action: Ensure the fire evacuation scheme has been approved by the fire service
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: PA Low
Evidence: A call bell policy is present. The call bells system is appropriate to the unit but is not yet fully functioning. There are call bells available in the dining and lounge rooms and bathrooms.
Finding: A call bell system has been installed in the PG unit, however, this is not yet fully functional
Corrective Action: Ensure that the call bell system is fully functional.
Timeframe (days): Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)
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

Attainment and Risk: FA
Evidence: General living areas include individualised panel wall heating in each bedroom, a ceiling heat pump in the dining/lounge area and radiator heating in the hallways.

Residents have access to natural light in their rooms and there is adequate external light in communal areas.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

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

Attainment and Risk: FA
Evidence: Leslie Groves has an infection control programme and written policies and procedures that comply with current best practice. There are IC policies infection control manual contains comprehensive information about the programme. The infection control programme was reviewed in February 2013. D 19.2a: Infection control policies include blood & body fluid exposure, hand hygiene, influenza, management of MRSA, outbreak management, standard precautions, sharps management, single use items, infection surveillance, cleaning disinfection and sterilisation. The risk management plan developed for the re-build includes infection prevention and control.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*