# Presbyterian Support Services Otago Incorporated - Iona

## Current Status: 28 November 2013

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

## General overview

Iona Home and Hospital is certified to provide hospital, (geriatric and medical) services and rest home level services for up to 78 residents. Current occupancy is 67 residents (21 rest home and 46 hospital).  
  
The service has addressed the two shortfalls from the previous two verification audits pertaining to issuing of a code of compliance certificate following rebuilding work. All 14 shortfalls from the previous certification audit have also been addressed.   
This audit identified no further improvements required.

## Audit Summary as at 28 November 2013

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 28 November 2013

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 28 November 2013

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 28 November 2013

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

### Safe and Appropriate Environment as at 28 November 2013

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 28 November 2013

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 28 November 2013

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# HealthCERT Aged Residential Care Audit Report (version 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:** | Presbyterian Support Otago |
| **Certificate name:** | Presbyterian Support Otago – Iona Home and Hospital |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | HDANZ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Iona Home and Hospital, Oamaru | | | |
| **Services audited:** | Rest home, Geriatric- hospital and medical | | | |
| **Dates of audit:** | **Start date:** | 28 November 2013 | **End date:** | 28 November 2013 |

|  |
| --- |
| **Proposed changes to current services (if any):** |
| Assessed one new resident room as part of the final stage of rebuild at Iona |

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 67 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11 | Total audit hours | 27 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 13 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 113 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **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 | Yes |
| 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 Friday, 20 December 2013

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Iona Home and Hospital is certified to provide hospital, medical and rest home level care for up to 78 residents. Current occupancy is 67 residents (21 rest home and 46 hospital).  The service has addressed the two shortfalls from the previous two verification audits pertaining to issuing of a code of compliance certificate following rebuilding work. All 14 shortfalls from the previous certification audit have also been addressed.  This audit identified no further improvements required. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. Education on informed consent has been provided. The complaints process and forms for completion were viewed on various notice boards throughout the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| Iona is managed by a registered nurse who reports to the director of services for older people, and is also supported by an operations support manager, a quality advisor and a clinical nurse advisor. Presbyterian Support Otago (PSO) quality and risk programme includes 16 Continuous Quality Improvement (CQI) groups that includes a number of clinically focused work streams. Work from CQI groups is reported to the six weekly managers meetings with a summary of any key clinical areas reported to an organisational clinical Governance Advisory group that includes board representation. PSO has a current business and quality plan to support quality and risk management at each facility. PSO Iona is implementing an internal audit programme and collating clinical data. There is a benchmarking programme in place across the organisation. Resident/relative surveys are undertaken bi-ennially. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents. The service has a documented training plan. The service has addressed and monitored shortfalls from previous certification audit around quality management and corrective actions, staff appraisals and implementing the in-service education programme. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Support plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing support plans. Support plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated three monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. The service has addressed and monitored previous shortfalls relating to assessments and care planning. The medication management system includes Medication Policy and Procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents’ general practitioner at least three monthly. The service has made improvements to aspects of medication management as identified at previous audit. A range of activities are available and residents provide feedback on the programme. The service has food policies/procedures for food services and menu planning appropriate for this type of service. Dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. The service has addressed and monitored previous shortfalls relating to recording of food and fridge temperatures. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The service displays a current building warrant of fitness. A certificate of Code of compliance has been issued by the local council relating to completed building and refurbishment work. Previous short falls from audits have been addressed in relation to hot water temperature monitoring and first aid training for staff.  A review of one further bedroom was conducted. The room is spacious with a full ensuite. The call bell system is in use. The room is yet to be occupied and it is intended for respite stay. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has three residents assessed as requiring restraint in the form of bedrails and one lapbelt; and four residents assessed as requiring enablers in the form of bedrails. There is a restraint register and an enablers register. Previous audit shortfall identified around review of restraint monitoring and use has been addressed and monitored. |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The infection control nurse at PSO Iona completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary. Previous audit shortfall around discussion of infection control matters with in quality structures has been addressed and monitored. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 22 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 57 |

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

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

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or registered nurses and a copy of any incident relating to individual residents is included in the clinical file. The family contact sheet records that families are informed following GP review, incidents or accidents or if there is a change in resident condition (confirmed by four relative interviews – one rest home and three hospital). Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in clinical files and an extensive admission booklet is given to all new residents and or family.  There is an interpreter policy in place with information included in the admission booklet.  D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet.  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 admission agreement and admission booklet. D16.4b Residents (eight) and relatives (four) interviewed confirmed they are kept fully informed.  D11.3 The admission booklet is available in large print and can be read to residents if required. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### Standard 1.1.13: Complaints Management **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. A complaints process form is available to record outcomes and this has been utilised for the eight complaints received for 2013. Details of the management of the complaints is recorded including letters of follow up and response. Complaints are discussed at the monthly quality and risk management meetings, at organisational level and at general and unit staff meetings. D13.3h. A complaints procedure is provided to residents within the information pack at entry. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Iona is part of Presbyterian Support Otago (PSO) Services for Older People. PSO provides services to the community in the form of services to older persons – residential and non-residential; and family works – a social support programme. There is a PSO Services for Older People organisational quality plan, philosophy and vision statement. There is also a business plan that includes strategic directions (2013-2014). There is a PSO governance structure includes a board made up of community and clinical representatives. Managers from all seven facilities report monthly to the Director of Services for the older person.  The nurse manager has been in the role for one year and is supported by a Clinical Nurse Advisor, Quality Advisor, Operations Support Manager and Director of Services for the older person.  The organisation implements a system of Continuous Quality Improvement groups that includes 16 work streams with membership coming from the facilities and includes but not limited to: benchmarking, competencies, dementia, falls, infection prevention and control, medications and Valuing Lives. There is a PSO and an Iona organisational chart. The organisation has adopted a “Valuing the lives of Older People” philosophy that is at varying stages of implementation at the different sites. The facility manager was absent on the day of audit. |

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

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

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

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

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

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

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

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

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO.  The business plan for 2013-2014 outlines the financial position for PSO with specific goals for the coming year. Goals and objectives relate to building strong and connected communities, provide leadership within the sector, and maximise resource to deliver on the PSO mission.   The quality plan for 2013 – 2014 includes the quality framework, model and processes, benchmarking, meetings, monitoring and reporting, internal and external audits, food safety, Valuing lives programme, policies and procedures, gaining feedback from residents and families, and ensuring a safe environment. A quality advisor has recently been employed to oversee the quality management systems and to provide further accountability for corrective actions and quality improvement initiatives. The organisation has 16 continuous quality improvement work streams in place, which include: infection control, documentation, continence, restraint, dementia, wound care, moving and handling, falls, medications, palliative care, policies and procedures, benchmarking, financial, competencies, workforce development, and Valuing lives. Each group is led by a designated manager/leader. The role of each group is to address the needs identified within each specialised work stream. Projects and issues are identified by the managers group (six weekly meeting) and allocated to the appropriate work stream for research, review and action planning.  Quality improvement initiatives for Iona have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently two documented quality improvement initiatives being implemented and relate to pre-admission visits to all prospective residents and conducting six weekly post admission review meetings with resident and family. Each QI has been reviewed for effectiveness of implemented actions. Iona is part of the PSO benchmarking programme with feedback provided three monthly on data provided to the benchmarking system. A report, summary and areas for improvement are received and actioned. The clinical advisory group also receives reports for all PSO homes and provides oversight and follow up on areas for improvement.   Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.   Progress with the quality assurance and risk management programme is monitored through the six weekly managers’ meetings, two monthly quality committee meetings, two monthly health and safety meetings, monthly registered nurse meetings and three monthly general staff meetings and monthly unit staff meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, wounds, complaints, and health and safety. The two monthly quality committee meeting agenda includes (but is not limited to): previous meetings minutes, food service, infection surveillance, complaints, laundry service, health and safety, occupancy, restraint, audits, surveys, internal benchmarking reports, activities, nursing/clinical, and review of action plans. Minutes are maintained (sighted for 15-Oct-2013) and staff have access to these meeting minutes in the staff room (confirmed by six care workers at interview). Registered nurse meeting agenda covers clinical issues, medication errors, education sessions and general business. Staff meetings agenda includes a report from the quality committee, internal audits, general housekeeping, and is followed by an education session (minutes sighted for July 2013). Minutes for all meetings include actions to achieve compliance where relevant. This, together with staff training, demonstrates Iona’s commitment to on-going quality improvement.  The service has made improvements in this area. Discussions with three registered nurses and six care workers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for 22-Nov-2013.  The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. D5.4 The service has comprehensive policies/ procedures to support service delivery.  D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. There are procedures to guide staff in managing clinical and non-clinical emergencies.  D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.  The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care workers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the nurse manager who completes any additional follow up. The nurse manager collates and analyses data to identify trends. Results are discussed with staff through the two monthly health and safety meetings, two monthly quality meetings, three monthly staff meetings, six weekly management meetings, and provided to the Quality Advisor for Internal benchmarking. Internal Audits for 2012/2013 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey (June 2012) and a family survey (June 2013) is conducted bi-annually. The surveys evidences that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via meetings (resident meeting minutes sighted for 17-Sept-2012) and a letter sent to all family with the survey outcomes. Corrective actions are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions. The service has made improvements in this area. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at two monthly quality committee meetings, two monthly health and safety meetings, six weekly management meetings, three monthly general staff meetings and monthly unit staff meetings including actions to minimise recurrence. Falls, medication errors and skin tears are reported and benchmarked through Internal Benchmarking programme. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and five family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incidents for October and November 2013 for three residents (one with four falls and two skin tears, one with three falls and one with four falls) were reviewed. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the respective unit manager. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Medication errors are also reported. A monthly summary of accidents and incidents is compiled by the facility manager with subsequent analysis and investigations. Trends and corrective actions are developed for staff to continue to improve on falls rates and to implement actions for falls prevention. D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses, podiatrist, pharmacists and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (two unit nurse managers, two registered nurses, two care workers and one food service manager). Advised that reference checks are completed before employment is offered as evidenced in three recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Six care workers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in seven of seven staff files reviewed.  Discussion with the two unit nurse managers, one quality advisor, three registered nurses and six care workers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Care workers have completed either the national certificate in care of the elderly or are working towards completion. The facility manager and registered nurses attend external training including conferences, seminars and sessions provided by PSO and the local DHB. The facility manager attends the six weekly managers’ meetings which includes education and training related to managing the facility.  Education provided in 2013 includes: food safety update, elder abuse and neglect, restraint minimisation and challenging behaviour management, infection control, medication management, back care, chemical handling, code of conduct, continence management, first aid training and orientation study day for new employees. This day includes topics around Valuing Lives (VLOP) programme, spirituality, moving and handling, health and safety, documentation and personal cares, restraint and continence. This is an improvement from the previous certification audit. Fire evacuation drill last conducted 8-Nov-2013. Annual appraisals are conducted for all staff as evidenced in five of seven files reviewed – two staff have commenced employment within the past 12 months. This is an improvement from the previous certification audit. |

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

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

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

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

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

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

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

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

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

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The staffing levels guide and Human Resources (HR) policies includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and hospital residents. A minimum of three staff are rostered on at any one time – two care workers and one registered nurse (RN) - with another RN on-call. The registered nurses share the on call roster. Roster includes: facility manager 40 hours per week and two unit nurse managers who work 40 hours each per week. There is at least one RN on every shift. The service is divided in to two units – Argyll rest home unit and Kirkness/Mackay hospital unit. Iona has the capacity to cater for either rest home or hospital residents in either unit – (swing beds) and currently there are eight hospital residents in the Argyll unit and three rest homes in the Kirkness/Mackay unit. Each unit has its own roster. In the rest home unit, there is either an RN or an EN on each morning duty with five care workers who work a mixture of short and long shifts. The afternoon shift has an RN or EN plus three care workers. Overnight there is one care worker on duty with extra care worker or RN cover provided from the hospital unit. The hospital unit has two RN’s on duty each morning and afternoon. There are eight care workers who work the long and short morning shift and seven care workers who work the afternoon shift. Two care workers work the night shift. There are cleaners employed in each unit who work every day. Other staff include physiotherapist, physiotherapist aide, activities staff, kitchen staff and maintenance and gardening staff. Interviews with three registered nurses, six care workers, eight residents and five family members identify that staffing is adequate to meet the needs of residents. |

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

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

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

## **Outcome 1.3: Continuum of Service Delivery**

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

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Lifestyle Support plans are developed by the service’s registered nurses who also have the responsibility for maintaining and reviewing support plans. An initial assessment and the beginning of the development of the residents care plan is expected to occur during admission. The full support plan is developed within three weeks. Lifestyle Support plans are developed in consultation with other relevant people including residents and where appropriate family/whanau. There was evidence of other allied health services input at the admission process i.e. GP, physiotherapy, dietitian, occupational therapist and podiatry. Five family members (one rest home, four hospital) interviewed confirmed their involvement and this involvement was documented. Care workers complete progress notes at the end of each shift, with registered nurse entries supporting as required. There is an appropriate hand-over briefing between shifts that staff were able to fully describe. D16.2, 3, 4: The six files reviewed (four hospital and two rest home) identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term support plan was completed within three weeks. There is documented evidence that the support plans are reviewed by a RN and amended when current health changes. All six support plans evidenced evaluations completed at least three 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 three monthly. A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); a) mobility assessment, b) pressure area assessment, c) falls risk assessment, d) nutritional needs assessment, e) continence assessment, and f) pain assessment. A short term care plan is completed by the registered nurses for changes in health status eg chest infections, urinary infections, and wound care.  Tracer Methodology: XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

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

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified improvements were required in relation to challenging behaviours and continence. A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) mobility assessment, b) pressure area assessment, c) falls risk assessment, d) nutritional needs assessment, e) continence assessment, f) pain assessment and if required challenging behaviour assessments and management plans. This previously identified shortfall is now met. |

##### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

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

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

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified improvement was required in relation to the level of care described in lifestyle support plans. In resident files reviewed (two rest home, four hospital) there is a long-term comprehensive support plan implemented for all areas of care needs. Lifestyle support plans demonstrate service integration. Resident files include lifestyle support plans, short term care planning, notes by GP and allied health professionals, significant events, communication with families and notes as required by a registered nurse. This previously identified shortfall is now met. |

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

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

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

#### Standard 1.3.6: Service Delivery/Interventions **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Overall, the lifestyle support plans are completed comprehensively and are personalised and individual to the resident. The care being provided is consistent with the needs of residents. This is evidenced by discussions with (six) caregivers ( two rest home, four hospital), eight residents (four rest home, four hospital) and five family members (one rest home, four hospital), three registered nurses, and two nurse unit managers. There is a short-term care plan that is used for acute or short-term changes in health status.   D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include an assessment for continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services was provided in July 2013. Wound management in-service was provided in August 2012. Wound assessment and wound management plans are in place for six residents. One wound was pressure related, which was identified as being sustained when resident was in public hospital.  The registered nurses (three) interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Lifestyle support plans are goal oriented and reviewed three monthly for rest home and hospital residents by a registered nurse.  During the tour of facility it was noted that all staff treated residents with respect and dignity, eight residents (four rest home, four hospital) and five family members (one rest home, four hospital), were able to confirm this observation.  GP interviewed confirmed that staff are prompt at communicating changes in resident health status and complete interventions as requested. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.5d Resident files reviewed (six -two rest home and four hospital)) evidenced resident profiles, assessment and activity interests, including individual goals in relation to activities. This previously identified shortfall is now met. A comprehensive resident social profile is completed on admission. There is a senior activities coordinator who works 32.5 hours per week and has been in the role for 20 years. Another three activities staff work a further 36 hours. The service also has volunteers to assist with their programmes and activities and they are overseen by the senior activities coordinator. The activities programme covers seven days a week. There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on the hallway notice board. Resident meetings occur monthly with activities as an agenda item. Residents are encouraged to participate in activities in the community.  There is a wide range of activities offered, that reflect the resident needs including but not limited to: newspaper reading, communion, church services, exercises, visiting entertainment, seasonal celebrations, hand massages, music, quizzes, baking, stories, craft, games, happy hour, van outings, play group every week, visits to and from local kindergarten and primary schools, shopping, movies, and crosswords. The activity programme is developed with the residents (and relatives) and this is reviewed two monthly by the activities team. |

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

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

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

#### Standard 1.3.8: Evaluation **(**HDS(C)S.2008:1.3.8)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.3c: All initial support plans are evaluated by the registered nurse and a lifestyle support plan developed within three weeks of admission. All six files (two rest home and four hospital) evidence that long-term support plans are evaluated at least three monthly for both rest home and hospital residents. There is evidence that the overall support plans have been reviewed and documented in the evaluation section of each corresponding aspect of the lifestyle support plan. The support plan evaluations indicate the degree of achievement of goals and objectives. This previously identified shortfall is now met. Registered nurses, care workers, other health professionals (as appropriate) resident and family are involved at the time of support plan review. GP advised that resident reviews and medication chart reviews are conducted every three months or more frequently as required. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are comprehensive medication management policies and procedures in place. Medications are managed appropriately in line with accepted guidelines.  The service uses four weekly blister pre-packed medication packs for all residents at Iona home and hospital. Medication charts have photo ID’s.  There is a signed agreement with the supplying pharmacy. Registered nurses advised that the list of medications printed on the back of medication packs are checked and reconciled against medication charts upon arrival to the facility by the night registered nurse and signed off when this check has been completed. This previously identified shortfall is now met. There are three medication trolleys at Iona. There is one locked medication room in MacKay hospital wing and a locked trolley stored in a locked cupboard. There is a large treatment room in Kirkness hospital wing in which a locked trolley is stored chained to the wall. This treatment room remains unlocked to allow staff access to emergency equipment stored within. In Argyle wing there is a locked medication cupboard in the nurses’ station where medications are stored and a locked cupboard for the medication trolley. All trolleys are locked when not in use. Two registered nurses were observed safely administering medications - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation.  There is a list of standing order medications that have been approved by the GP's for each individual resident. Staff sign for the administration of medications on medication sheets held with the medicines. A list of specimen signatures and competencies is kept in the front of each (three) medication folders. There are three locked safes for controlled drugs - one in each wing - and three controlled drug registers for the safekeeping and administration of controlled drugs for residents. Controlled drugs are: checked in to the locked safes by Pharmacy staff and a registered nurse; checked weekly by staff; and six monthly by Pharmacist. Controlled drug books shows evidence of two signatures for all controlled drug administration. There are minimal stock drugs kept and these are checked periodically. Three medication fridge temperatures are monitored daily. Registered nurses administer medications in the Kirkness and Mackay hospital wing, and an enrolled nurse and registered nurses administer medication in the Argyle rest home wing. There is a list of staff competencies maintained in the education folder and all staff administering medications have passed their competency.  Unused medications and expired medications are returned to pharmacy. Medication charts for 12 residents were reviewed - four rest home residents and eight hospital residents. There is evidence of GP reviewing medication charts for each resident three monthly - confirmed at GP interview. Previous audit identified transcribing of medication instructions occurring. On review of 12 medication documentation it was evident this practice no longer occurs.  Allergies are recorded in the medical admission sheet, and on the medication charts.  The service records all medication errors as incidents/accidents and these are followed up, reported in graph form, monthly and benchmarked with the other PSO facilities on a three monthly basis. Where appropriate, corrective action is discussed at the staff meetings and registered nurse meetings.  The service has a policy and procedure on residents who wish to self-medicate that eludes three monthly assessments by GP of the resident's on-going ability to safely self-medicate and a resident competency review form. There are currently no residents self-medicating at Iona home and hospital.  D16.5.e.i.2: Twelve medication charts were reviewed and identified that the GP had seen the resident three monthly and the medication chart was signed. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. |

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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

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

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

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

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

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

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| PSO Iona home and hospital has a well-run food service that is managed by an experienced kitchen supervisor. All meals for Iona residents are prepared and cooked on site. The kitchen supervisor has been in the role for over 25 years and advised that she and all kitchen staff have completed food safety qualifications.  Iona kitchen has an accredited Food Safety Programme (HACCP)  The four weekly menu is designed by the organisation's dietitian - last reviewed November 2012.  The food service is notified of dietary requirements via a dietary requirements form, which is completed by the registered nurse and sent through to the kitchen. It includes likes and dislikes, modified diets and preferences. The service provides special equipment eg utensils, lip plates and sipper cups as required. Meals are transported via tray service to Mackay and Kirkness wings and to those residents unable to attend meals in the dining rooms. Hot food temperature recordings are taken for all hot dishes prior to serving. Fridge and freezer temperatures are monitored daily. This previously identified shortfall is now met. There are two large fridges, a walk in chiller and a large freezer. Food stored in the fridges and freezer is covered and labelled with a day of the week sticker. The kitchen pantry has extra food stores - enough for three days if required in an emergency, including adequate water supply.  A registered dietitian conducts nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues. Information is documented in the daily care interventions and in the integrated support plan if there is an identified nutritional issue.  Resident weights are monitored monthly or more frequently if required.  Residents interviewed were complimentary of the food service. |

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

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

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

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

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

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

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

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

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility displays a current building warrant of fitness, which expires on 1-July-2014. The fire evacuation scheme has been reviewed and is dated 22-June-2013. Code of Compliance certificates have been issued for the completed building and refurbishment work of the hospital wing. The service has addressed the previous verification audit finding. |

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

All buildings, plant, and equipment comply with legislation.

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

#### 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:** |
| Previous certification audit finding (#1.4.3.2) around hot water temperatures not being within acceptable limits. Monthly hot water temperatures are monitored and recorded (sighted) and evidence that resident areas (bathroom, hand basins, showers) are now within acceptable limits. Records from July 2013 – November 2013 were reviewed. All temperatures were recorded as being within 41 degrees Celsius and 45 degrees Celsius. This is an improvement from the previous audit. |

##### **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 1.4.7: 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:** FA |
| **Evidence:** |
| The previous audit identified that first aid training had not been provided to registered nursing staff or activities staff (finding #1.4.7.2). Records reviewed and unit managers interviewed evidenced that all registered nurses are now trained in first aid and CPR and all activities staff have current first aid certificates. The service has made improvements in this area. |

##### **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.)* |

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies around restraint, enablers and the management of challenging behaviours, which meet requirements of HDSS 2008. The service currently has three hospital residents assessed as requiring restraint (two bedrails and one lap belt) and four hospital residents using enablers (all bedrails). Policy dictates that enablers should be voluntary and the least restrictive option possible. Two unit nurse managers, three registered nurses and six care workers are familiar with this. The restraint coordinator (a registered nurse) was not on duty and was therefore unable to be interviewed. Restraint/enabler use is discussed at quality meetings, at health and safety meetings and at registered nurse meetings. Restraint use audit conducted August 2013.  Staff received training around restraint minimisation and safe practice in May and October 2013. Management of challenging behaviours education was provided in October 2013. Restraint questionnaires and competency are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. |

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

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

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous certification audit identified that a system for restraint use monitoring and review had not been implemented. The service has taken steps to address this finding. Restraint review has been conducted and is discussed at Health and safety meetings, registered nurse meetings and management meetings. The service has been active in reducing the use of restraint – from 22 residents on restraint in August 2012 down to seven residents in November 2013. Restraint use is reported at organisational level and is a CQI workstream. The service has made improvements in this area. |

##### **Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:  
(a) The extent of restraint use and any trends;  
(b) The organisation's progress in reducing restraint;  
(c) Adverse outcomes;  
(d) Service provider compliance with policies and procedures;  
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  
(g) Whether changes to policy, procedures, or guidelines are required; and  
(h) Whether there are additional education or training needs or changes required to existing education.

|  |
| --- |
| **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 3.1: Infection control management **(**HDS(IPC)S.2008:3.1)

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous certification audit identified that infection control matters were not incorporated in to the quality/meeting structure. The service has addressed and monitored this area. Infection control and infection rates and incidents are an agenda item at staff meetings, registered nurse meetings, management meetings, health and safety meetings and quality/CQI meetings. Infection rates are communicated to staff via meetings and meeting minutes. Graphs and tables are displayed for staff to read in the staff room. The infection control nurse (rest home unit manager) reports to the registered nurse monthly meetings on clinical issues relating to infection prevention and control. Infection control is also discussed at the weekly management team meeting at Iona. The service has made improvements in this area. |

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality/CQI meetings, monthly registered nurse meetings and monthly unit staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager and to organisational management. The rest home unit nurse manager is the designated infection control nurse. |

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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

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