

Kaylex Care (Fielding) Limited

Current Status: 2 December 2013

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

General overview

Woodfall Lodge in Feilding is owned by Kaylex Care (Fielding) Ltd. Woodfall Lodge provides rest home and hospital level of care for up to 36 residents. On the day of audit there are 35 residents.

There are five areas identified for improvement. These relate to privacy, time frames for the medical reviews of residents, planning of activities, evaluation of care, timely responses to answering call bells, and a number of risks that require actions to be implemented urgently, related to the systems and processes for ensuring a safe medicine management system. The organisational management team demonstrate commitment to addressing areas identified for improvement and embedding the organisational continuous quality improvement programmes.

Audit Summary as at 2 December 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 2 December 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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 2 December 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.
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Continuum of Service Delivery as at 2 December 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 2 December 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.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 2 December 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.
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Infection Prevention and Control as at 2 December 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.
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Audit Results as at 2 December 2013

Consumer Rights

Documented procedures, interviews with residents, family members and staff, together with observations, confirm that residents' rights are understood and met in everyday practice, with one exception. Maintaining residents' physical privacy is an area requiring improvement. Processes are implemented to identify and meet individual resident's needs, including cultural and spiritual needs.

Residents are free from discrimination and have access to advocacy services. Reports or allegations from residents regarding concerns are followed up and addressed in a timely and appropriate manner. Residents' meetings occur and the managers have an 'open-door' policy. Residents and family interviewed confirm communication is open and timely. All current residents speak English. Staff can identify how interpreters are accessed if required.

Informed consent requirements are clearly defined and residents and staff member interviews confirm choice is given and informed consent is facilitated. Advance directives are documented where applicable and communicated to staff.

Links with community resources are supported and facilitated. Visitors are free to come and go as requested by the resident.

The service has an easily accessed and responsive complaints process, which is documented and complies with the time frames set in the Code of Health and Disability Services Consumers' Rights (the Code). An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. The 2013 data records two complaints that have been received through the District Health Board. One previous complaint, which is now closed by the Health and Disability Commissioner, required that the recommendations related to family communication and documentation in the residents' progress notes are followed up at this audit. There is evidence that the recommendations have been implemented and embedded in practice.

Organisational Management

Woodfall Lodge is part of the Kaylex Care group of facilities. The organisation's purpose, values and goals are clearly identified and displayed at the service. The service is planned and coordinated to deliver services that meet the needs of residents at rest home and hospital level of care.

The service has had a recent change of the onsite facility manager. At the time of audit the service is managed part time, by a temporary facility manager, who also manages one of the other Kaylex Care facilities. The temporary facility manager is a suitably qualified and experienced registered nurse, with current management experience and training. The facility manager is supported by the Kaylex Care organisational management and a full time onsite clinical care manager.

The organisational quality and risk management plan is implemented at the service. The quality processes are reviewed and measured through the internal audit schedule, complaints management, satisfaction survey results, data collation and review, and staff and family/whanau

meetings. The quality data is benchmarked with the other two facilities that Kaylex Care own and manage. All quality and risk activities are monitored by the facility manager and the organisational management team. The quality data is analysed and used as an opportunity to improve services wherever possible.

The service implements safe staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and ensure that legislative requirements are met. Staff members' knowledge and skills are maintained through on-going education which is appropriate to their role.

Documentation is made in residents' notes in a timely manner. Residents' files are maintained securely.

Continuum of Service Delivery

There are clearly documented processes for entry to the facility. Adequate information about Woodfall Lodge is made available to prospective residents. Copies of the Support Link assessments are held in residents' files.

Care and support is provided by a range of health professionals. This includes the clinical care manager (CCM), who is a registered nurse, trained caregivers, general practitioners and visiting allied health professionals. There is a registered nurse rostered on duty at all times.

Nursing assessments and care plans are clearly documented. Interventions are consistent with good practice and desired outcomes and are individualised for residents' needs. Care plans are reviewed every six months, or sooner if required. Short term care plans are developed as required. However, evaluations are not always present or sufficiently documented and this is an area requiring improvement.

Areas requiring improvement are identified in relation to ensuring residents are assessed by the GP as stable and suitable for three monthly reviews (rather than monthly), ensuring routine GP reviews occur in a timely manner and that records are available following all reviews. The GP interviewed confirms changing needs of residents are communicated in a timely manner.

Residents maintain access to a range of health services. Referrals and transfers are managed in a timely and appropriate manner. There is evidence that residents and family are involved.

Assessments are undertaken to identify residents' interests, hobbies, and ability is considered. The activities programme is developed and distributed to residents weekly. The activities for hospital level residents are more appropriate for physically able residents and this is an area requiring improvement.

Policies and procedures detail how medication should be managed. Staff are assessed as competent to administer medications. All medications are stored securely. Improvements are required to ensure all prescribing meets requirements; medication/fluid is given as prescribed (or noted as refused or withheld); medication is stored at an appropriate temperature; and controlled drugs are managed in accordance with legislative requirements. Processes are implemented to ensure applicable residents can self-administer their medications safely.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietitian. Individual resident's needs are catered for and monitored. Food preparation and storage meets food safety requirements.

Safe and Appropriate Environment

The service provides single room accommodation for up to 36 residents. There are separate rest home and hospital level of care wings in the facility. The residents are provided with adequate personal space in their rooms which are large enough to allow residents, with or without mobility aids, to move around safely. The residents are provided with adequate toilet, shower and bathing facilities. Two of the rooms have full ensuites, the remaining rooms have access to facilities that are conveniently located in each of the wings. Residents are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. There are lounge and dining areas in both the rest home and hospital sections of the service. The residents are provided with safe and hygienic cleaning and laundry services. All resident areas have adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

The building has a current warrant of fitness and there is an ongoing maintenance plan to ensure the residents are provided with an appropriate and accessible physical environment. There are safe processes in place for the management of waste and hazardous substances. The service has appropriate procedures and supplies to provide essential, emergency and security systems, which includes fire safety. Staff receive appropriate information, training, and have equipment to respond to identified emergency and security situations. The service has a call bell system to request assistance when required; some of the residents interviewed report that the response time can be slow at times. An improvement is required related to the response times in answering the call bells.

Restraint Minimisation and Safe Practice

The service has policies, procedures and processes in place to actively minimise the use of restraint. At the time of audit, there is one resident assessed as requiring restraint (a lap belt) and no residents who require enabler use. Where restraints are used, the restraint approval process and assessment is conducted to ensure the restraint is the least restrictive option to maintain the resident's safety and used for the shortest time possible. When enablers are used, these are voluntary and the least restrictive option for the resident.

Staff education is undertaken as part of orientation and as part of regular on-going in-service education. Staff demonstrate their understanding of the restraint minimisation policy and procedures and the definition of restraint and enablers. The service conducts quality reviews and evaluation of the restraints used to ensure restraints is used for the least amount of time. The use of restraint is part of the quality and risk systems that are monitored by the organisation's head office management processes.

Infection Prevention and Control

Woodfall Lodge has a current infection prevention and control programme, recently reviewed by the acting facility manager. The clinical care manager (CCM) is responsible for facilitating the infection prevention and control programme and has attended a recent in-service education

session on infection prevention and control. The CCM can identify who advice and support would be obtained from if required.

Relevant policies and procedures are available for staff. The policies have been developed by an external infection prevention and control consultant.

Surveillance is occurring for residents who develop infections. The surveillance is appropriate to the service setting. The infection rates are reported and analysed monthly and are benchmarked with the other two aged care facilities owned by the same owner. Staff are provided with feedback on infections and reduction strategies in a timely manner.

Education is occurring with residents on infection prevention activities.

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:	Kaylex Care (Fielding) Limited		
Certificate name:	Woodfall Lodge Retirement Home		
Designated Auditing Agency:	DAA Group		
Types of audit:	Certification		
Premises audited:	Woodfall Lodge, 2-4 Bowen Street, Feilding		
Services audited:	Rest Home and Hospital Level of Care		
Dates of audit:	Start date: 2 December 2013	End date: 3 December 2013	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			35

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	10
Other Auditors	XXXX	Total hours on site	16	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	3

Sample Totals

Total audit hours on site	32	Total audit hours off site	21	Total audit hours	53
Number of residents interviewed	7	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	35	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the 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 Monday, 23 December 2013

Executive Summary of Audit

General Overview

Woodfall Lodge in Feilding is owned by Kaylex Care (Fielding) Ltd. Woodfall Lodge provides rest home and hospital level of care for up to 36 residents. On the day of audit there are 35 residents.

There are five areas identified for improvement. These relate to privacy, time frames for the medical reviews of residents, planning of activities, evaluation of care, timely responses to answering call bells, and a number of risks that require actions to be implemented urgently, related to the systems and processes for ensuring a safe medicine management system. The organisational management team demonstrate commitment to addressing areas identified for improvement and embedding the organisational continuous quality improvement programmes.

Outcome 1.1: Consumer Rights

Documented procedures, interviews with residents, family members and staff, together with observations, confirm that residents' rights are understood and met in everyday practice, with one exception. Maintaining residents' physical privacy is an area requiring improvement. Processes are implemented to identify and meet individual resident's needs, including cultural and spiritual needs.

Residents are free from discrimination and have access to advocacy services. Reports or allegations from residents regarding concerns are followed up and addressed in a timely and appropriate manner. Residents' meetings occur and the managers have an 'open-door' policy. Residents and family interviewed confirm communication is open and timely. All current residents speak English. Staff can identify how interpreters are accessed if required.

Informed consent requirements are clearly defined and residents and staff member interviews confirm choice is given and informed consent is facilitated. Advance directives are documented where applicable and communicated to staff.

Links with community resources are supported and facilitated. Visitors are free to come and go as requested by the resident.

The service has an easily accessed and responsive complaints process, which is documented and complies with the time frames set in the Code of Health and Disability Services Consumers' Rights (the Code). An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. The 2013 data records two complaints that have been received through the District Health Board. One previous complaint in 2012, which is now closed by the Health and Disability Commissioner, required that the recommendations related to family communication and documentation in the residents' progress notes are followed up at this audit. There is evidence that the recommendations have been implemented and embedded in practice.

Outcome 1.2: Organisational Management

Woodfall Lodge is part of the Kaylex Care group of facilities. The organisation's purpose, values and goals are clearly identified and displayed at the service. The service is planned and coordinated to deliver services that meet the needs of residents at rest home and hospital level of care.

The service has had a recent change of the onsite facility manager. At the time of audit the service is managed part time, by a temporary facility manager, who also manages one of the other Kaylex Care facilities. The temporary facility manager is a suitably qualified and experienced registered nurse, with current management experience and training. The facility manager is supported by the Kaylex Care organisational management and a full time onsite clinical care manager.

The organisational quality and risk management plan is implemented at the service. The quality processes are reviewed and measured through the internal audit schedule, complaints management, satisfaction survey results, data collation and review, and staff and family/whanau meetings. The quality data is benchmarked with the other two facilities that Kaylex Care own and manage. All quality and risk activities are monitored by the facility manager and the organisational management team. The quality data is analysed and used as an opportunity to improve services wherever possible.

The service implements safe staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and ensure that legislative requirements are met. Staff members' knowledge and skills are maintained through on-going education which is appropriate to their role.

Documentation is made in residents' notes in a timely manner. Residents' files are maintained securely.

Outcome 1.3: Continuum of Service Delivery

There are clearly documented processes for entry to the facility. Adequate information about Woodfall Lodge is made available to prospective residents. Copies of the Support Link assessments are held in residents' files.

Care and support is provided by a range of health professionals. This includes the clinical care manager (CCM), who is a registered nurse, trained caregivers, general practitioners and visiting allied health professionals. There is a registered nurse rostered on duty at all times.

Nursing assessments and care plans are clearly documented. Interventions are consistent with good practice and desired outcomes and are individualised for residents' needs. Care plans are reviewed every six months, or sooner if required. Short term care plans are developed as required. However, evaluations are not always present or sufficiently documented and this is an area requiring improvement.

Areas requiring improvement are identified in relation to ensuring residents are assessed by the GP as stable and suitable for three monthly reviews (rather than monthly), ensuring routine GP reviews occur in a timely manner and that records are available following all reviews. The GP interviewed confirms changing needs of residents are communicated in a timely manner.

Residents maintain access to a range of health services. Referrals and transfers are managed in a timely and appropriate manner. There is evidence that residents and family are involved.

Assessments are undertaken to identify residents' interests, hobbies, and ability is considered. The activities programme is developed and distributed to residents weekly. The activities for hospital level residents are more appropriate for physically able residents and this is an area requiring improvement.

Policies and procedures detail how medication should be managed. Staff are assessed as competent to administer medications. All medications are stored securely. Improvements are required to ensure all prescribing meets requirements; medication/fluid is given as prescribed (or noted as refused or withheld); medication is stored at an appropriate temperature; and controlled drugs are managed in accordance with legislative requirements. Processes are implemented to ensure applicable residents can self-administer their medications safely.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietitian. Individual resident's needs are catered for and monitored. Food preparation and storage meets food safety requirements.

Outcome 1.4: Safe and Appropriate Environment

The service provides single room accommodation for up to 36 residents. There are separate rest home and hospital level of care wings in the facility. The residents are provided with adequate personal space in their rooms which are large enough to allow residents, with or without mobility aids, to move around safely. The residents are provided with adequate toilet, shower and bathing facilities. Two of the rooms have full ensuites, the remaining rooms have access to facilities that are conveniently located in each of the wings. Residents are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. There are lounge and dining areas in both the rest home and hospital sections of the service. The residents are provided with safe and hygienic cleaning and laundry services. All resident areas have adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

The building has a current warrant of fitness and there is an ongoing maintenance plan to ensure the residents are provided with an appropriate and accessible physical environment. There are safe processes in place for the management of waste and hazardous substances. The service has appropriate procedures and supplies to provide essential, emergency and security systems, which includes fire safety. Staff receive appropriate information, training, and have equipment to respond to identified emergency and security situations. The service has a call bell system to request assistance when required; some of the residents interviewed report that the response time can be slow at times. An improvement is required related to the response times in answering the call bells.

Outcome 2: Restraint Minimisation and Safe Practice

The service has policies, procedures and processes in place to actively minimise the use of restraint. At the time of audit, there is one resident assessed as requiring restraint (a lap belt) and no residents who require enabler use. Where restraints are used, the restraint approval process and assessment is conducted to ensure the restraint is the least restrictive option to maintain the resident's safety and used for the shortest time possible. When enablers are used, these are voluntary and the least restrictive option for the resident.

Staff education is undertaken as part of orientation and as part of regular on-going in-service education. Staff demonstrate their understanding of the restraint minimisation policy and procedures and the definition of restraint and enablers. The service conducts quality reviews and evaluation of the restraints used to ensure restraints is used for the least amount of time. The use of restraint is part of the quality and risk systems that are monitored by the organisation's head office management processes.

Outcome 3: Infection Prevention and Control

Woodfall Lodge has an infection prevention and control programme dated 2012/2013. This was recently reviewed by the acting facility manager. The clinical care manager (CCM) is responsible for facilitating the infection prevention and control programme and has attended a recent in-service education session on infection prevention and control. The CCM can identify who advice and support would be obtained from if required.

Relevant policies and procedures are available for staff. The policies have been developed by an external infection prevention and control consultant.

Surveillance is occurring for residents who develop infections. The surveillance is appropriate to the service setting. The infection rates are reported and analysed monthly and are benchmarked with the other two aged care facilities owned by the same owner. Staff are provided with feedback on infections and reduction strategies in a timely manner.

Education is occurring with residents on infection prevention activities.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	44	0	2	3	1	0
Criteria	0	95	0	2	3	1	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.1.3.1	The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.	PA Low	Four of seven residents interviewed advised their personal privacy while in the bathroom is not always maintained as staff come in the bathroom looking for things and do not always knock	Ensure the physical privacy of residents is maintained.	180
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	<p>1) There is no documentation in the sampled residents' files to identify the GP has assessed that the resident is stable and suitable for three monthly reviews (rather than one monthly reviews) as required in the ARRC contract.</p> <p>2) Records are not available to demonstrate that all residents are being routinely reviewed at least three monthly.</p> <p>3) There are a number of GPs providing service who type electronic records following resident review. A copy of some of the GP review notes is not available in some of the residents' files sighted during audit.</p>	<p>1) Ensure the medical practitioner identifies that residents are stable and suitable for three monthly reviews.</p> <p>2) Ensure that residents are routinely reviewed at the required frequency (as determined by the GP) and that records of all consultations are obtained and included in the resident clinical records.</p>	90
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	An activities programme for hospital level care residents has commenced in the last six weeks. There is one hour of activities scheduled weekdays afternoons specifically for hospital level residents (although some residents do attend some of the rest home activities). The activities provided for hospital level residents do not encourage resident participation as the activities are more applicable to more physically able residents. Residents interviewed advised they did not attend many activities as they could not participate or did not like the activity.	Ensure the activities programme is appropriate to the service setting and needs of hospital level residents	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	Evaluations are not always occurring or are sufficiently documented in residents' files sampled.	Ensure evaluations are sufficiently documented to identify the effectiveness of care provided and/or progress to achieving the desired outcome.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	<p>1 Nursing staff are transcribing medications on charts for review and signing by the medical practitioners when the current chart in use requires rewriting. The date that is being noted is the date the medication chart is rewritten and not the date the medications commenced.</p> <p>2 'White out' is noted used on medication records to remove column marks and enable indications for use to be documented without lines.</p> <p>3 The refrigerator that is used for the storage of medication is noted to be outside of the required temperature range most days in November with a temperature as low as minus three degrees Celsius recorded. There is no evidence of review or follow-up</p> <p>4. Not all regular prescribed medications are signed as given or noted as withheld or refused. A resident is documented as receiving respiratory inhalers only 42 doses out of 60 prescribed doses in October 2013. Another resident is charted lactulose 20 mls BD and is not being given. 5 One resident is noted to have refused a dose of 10 mg M-eslon. There is no documentation available to evidence what happened to this tablet. It was not returned into the CD register or documented as being returned to pharmacy.</p>	Ensure all components of medication management meet legislative requirements and current accepted practice.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Low	Four the seven residents interviewed report their call bells are not always answered in a timely manner.	Ensure staff response to the call bell system to request assistance is conducted in a timely manner.	180

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 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

DOCUMENT REVIEW: The submitted Consumer Rights policy states that the Code will be made known to all new employed staff and new residents on admission and the appropriate method and communication preference will be adapted to ensure that residents have been fully informed and that the Code and Rights have been understood.

Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is included in the information pack given to prospective and new residents as verified during audit.

Eight residents (three rest home and five hospital level care) and five family members (two rest home and three hospital level care) interviewed report they are well treated and confirmed staff are respectful of their rights with one exception. This related to maintaining physical privacy while in the bathroom and is raised as an area for improvement in 1.1.3.1.

Staff receive training on residents' rights and the Code of Health and Disability Services Consumers' Rights (the Code) during orientation. Additional training on the Code (and advocacy services) has been provided in September 2013 and this was attended by 11 staff.

Six of six caregivers, the RN and the clinical care manager (CCM) interviewed are able to verbalise how they incorporate the principles of the Code into every day practice. This extends to verbal consent, open communication, facilitating the resident to be as independent as safely possible and facilitating the resident's right to refuse or request alternative care.

One general practitioner (GP) is interviewed and reports no concerns regarding residents' rights.

ARRC contract requirements are met.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

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

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA
Evidence: <p>DOCUMENT REVIEW: The submitted Consumer Rights policy states that all Residents/Family/Whanau receive a copy of the code as part of the information we provide on admission and opportunities are provided for Residents/Family/Whanau and staff to discuss any issues related to the code.</p> <p>Seven of eight residents (three rest home and four hospital level care) and three of five family members (one rest home and two hospital level care) confirm being provided with information on the Code and advocacy services as a component of the admission process. One hospital level resident and family member confirm being provided with a facility welcome pack but have not reviewed the contents as at the time of audit. The family member of a rest home resident is unaware of what information was provided during admission as another family member was involved with this process. The resident however, confirms being fully informed.</p> <p>The CCN and RN interviewed advise residents are provided with an opportunity to discuss anything either prior to admission, during the admission or subsequently.</p>

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

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

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

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

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

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

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

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

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

Attainment and Risk: PA Low

Evidence:

DOCUMENT REVIEW: The submitted Privacy and Confidentiality policy states 'Our facility is committed to meeting the requirements of the Privacy Act 1993, the Health Information Privacy Code 1994 and the Health (Retention of Information) Regulations 1996. All information is collected in a situation of confidence and trust. The policy adequately describes how the service collects and uses health information, storage of such information, and how it protects resident's physical, visual and auditory privacy and their belongings. There is also a process for submitting complaints to the Privacy Commission. The submitted Cultural Awareness and Safety Policy and Recognition of Individual Values and Beliefs policy describe processes and systems for safe cultural practices and service delivery.

Residents are encouraged to set goals for independence as a component of care planning. This is confirmed in residents' records sampled and care plans clearly describe the level of support required. Residents are observed during the audit participating in a range of self-care activities and staff are provided with guidance on how independence can be achieved/maintained. The caregivers confirm the care plans are sufficiently detailed to inform them of individual resident's care needs.

All residents have a private room which contain personal belongings. While staff are observed knocking on resident's doors and being invited to enter, four of seven residents interviewed advise their physical privacy in the bathroom is not always respected and this is an area requiring improvement.

Interviews and observations confirm that Woodfall Lodge is committed to ensuring residents are not subjected to abuse or neglect. The different types of abuse and neglect are defined within policies and guidelines. Management is able to provide evidence that they respond to any reports of alleged abuse or neglect or staff overstepping boundaries in an appropriate and timely manner. Staff receive training on abuse and neglect. Training was last provided in June 2013.

All eight (three rest home and five hospital level care) residents interviewed state they feel safe and well care for and confirm being provided with choice on day to day activities and cares provided. This includes safety regarding cultural and spiritual needs. The five family members interviewed advise they have no concerns about how their family member is being cared for. The family members advise they have never had any reason to be concerned about how staff interact with other residents during their visits.

The care plans sighted promote quality of life and maximising the resident independence.

ARRC contract requirements are met except D 3.1f.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

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

Attainment and Risk: PA Low

Evidence:

A tour of the facility confirms that all residents have a private room which contain personal belongings. Staff are sighted knocking and waiting to be invited before entering

the resident's bedroom. Four of seven residents interviewed advise their physical privacy is not always respected while they are in the bathroom. At times staff come in looking for gloves or other items and this is an area requiring improvement. The resident's confirm their auditory privacy is maintained.

Finding:

Four of seven residents interviewed advised their personal privacy while in the bathroom is not always maintained as staff come in the bathroom looking for things and do not always knock

Corrective Action:

Ensure the physical privacy of residents is maintained.

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

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

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

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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

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

Attainment and Risk: FA

Evidence:

Finding:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

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

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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

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

Attainment and Risk: FA
Evidence: DOCUMENT REVIEW: The submitted Maori Health Policy states 'Residents who identify as Maori have their health and disability needs met in a manner that respects and acknowledges their individual values and beliefs. It further describes a philosophy and approach underpinned by the principles of the Treaty of Waitangi. The policy proposes that clinical care for Maori residents be based on Te Whare Tapa Wha. The submitted Maori health policy states "the organisation is committed to meeting the Health outcomes in the Korowai Oranga (Maori health strategy) through –
<ul style="list-style-type: none"> - Building strong partnerships with Maori communities - Contributing to the development of Maori workforce - Improving the effectiveness of main stream services to accommodate the needs of elderly Maori - Increasing the number of quality services provided for and by Maori - Increasing the understanding of the role and significance of Kaumatua Te Ao Maori (Maori world)."

The CCM identifies her ethnicity as Maori and stated a commitment to ensuring individual resident needs (including cultural) are met. The CCM advises the only known barriers for Maori residents accessing services is requiring a needs assessment to verify that rest home or hospital level care is required and bed availability.

At audit there is one resident who identifies her ethnicity as Maori. This is noted in the resident's care plan although the resident advises she wants to be treated 'like everybody else'. The care plan notes the resident is called by a title of respect for older persons in Maoridom. Staff are provided with guidance on how to pronounce this title and are observed calling the resident by this title during audit. The resident's family member confirms that while the resident has not been in the facility very long there is satisfaction with all aspects of the services being provided. The family member confirms they are actively encouraged to visit and participate in everything.

The ARRC requirements are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

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

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with 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.)

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported 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 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

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

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

Attainment and Risk: FA

Evidence:

DOCUMENT REVIEW: The submitted Maori Health, Cultural Awareness and Safety policy and the Recognition of Individual Values and Beliefs policy describe service expectations in regards to assessing and meeting cultural and individual values and beliefs.

The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support the needs of residents. Ethnicity, cultural and spiritual needs are identified during the initial assessment and this is evident in the seven (four rest home and three hospital) residents' records sampled.

Eight (three rest home and five hospital level care) residents and four of four family members interviewed on this component indicate that they are consulted in the identification of spiritual, religious and/or cultural beliefs. Residents can access church services if requested. Church services (facilitated by the Anglican Church) but any resident can attend are held on site monthly. The activities coordinator advises these are not well attended. The hospital level care resident is visited by a church representative weekly and this includes communion. The resident's family member advises staff are aware of the importance of this to the resident and worked to ensure this can be done safely as the resident has some swallowing difficulties.

The ARRC contract requirement is met.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

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

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

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: <p>DOCUMENT REVIEW: There is a fully described Harassment policy which states the facility is committed to providing a safe working environment and eliminating all forms of harassment from its work place. The service regards harassment (on any of the grounds set out in the Human Rights Act 1993 or the Employment Relations Act 2000) as serious misconduct. It further describes and defines harassment, specifically sexual harassment and bullying and actions to be taken.</p> <p>Any form of discrimination is not acceptable within the organisation. Staff receive training on discrimination and the code of conduct (most recently in September 2013).</p> <p>Six of six care givers interviewed understand the organisation's policy on acceptance of gifts and expected conduct. The RN interviewed is aware of the code of conduct and also the requirements of the Nursing Council of New Zealand. The facility manager (FM) advises any reported breach is investigated and followed up via appropriate human resource processes. This is verified to have occurred following a reported event.</p> <p>Eight residents and the four family members interviewed on this topic confirm they are not subject to discrimination.</p>

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

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

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

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA
Evidence: <p>The nursing process is used for all assessments, care planning and evaluations. Nursing assessment and care plans have been developed for all residents using interRAI. The residents' files sampled during audit demonstrates detailed assessments and detailed care plans are available to guide the provision of care. Not all residents are being reviewed by the general practitioners in the time frames required by the ARRC contract. This is raised as an area for improvement in 1.3.3.3. A number of aspects of medication practice required review. This is raised as an area for improvement in 1.3.12.1.</p> <p>Policies and procedures are available for staff on relevant components of service delivery. There are sufficient supplies of continence and wound care products to meet the residents assessed care needs. Pressure relieving mattresses and cushions are used for at risk residents.</p> <p>Surveillance for infections is occurring. There is benchmarking of data with the two other facilities owned by Kaylex Care.</p> <p>The GP interviewed states that appropriate interventions are implemented for the management and treatment of health care needs. Specialist services including stoma, wound care and palliative care services are sought from DHB staff and or Hospice services as appropriate as evidenced in sampled files.</p> <p>Services are overseen by an experienced CCM who (in interview) is able to demonstrate a good understanding of the monitoring needs of rest home and hospital residents.</p> <p>The ARRC requirements are met.</p>

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

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

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

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: <p>DOCUMENT REVIEW: The submitted Open Disclosure Policy adequately defines and describes the principles of open disclosure and how the service practices this. The submitted Interpretation and translation policy states 'All residents and their families have the right to comprehensive information about our home and the services that we provide, as well as care planning and implementation. This information is supplied in a way that is appropriate for the resident and/or their family and takes account of specific language requirements and any disabilities that the resident may have.' The policy describes the role of interpreters and their use and contains current contact information for a variety of services who could provide interpreters and cultural advice locally.</p> <p>Incidents and adverse events are managed in an open manner and there is clear evidence of family contact in relation to reported incidents and changes in the resident's health care needs. Communication with family is documented on the incident report and or in the residents' progress notes with one exception noted at audit in the six resident files sampled. There is no documentation to evidence family were informed when a resident absconded. The resident's family confirms being phoned and informed immediately the resident could not be located. All four family members interviewed verify they are kept fully informed of all changes in the resident's care needs and when there are reported events. The CCM is also sending an updated written summary following the six monthly care review meetings as sighted in two resident files following the most recent review.</p> <p>All staff are identifiable. Staff wear name badges and a uniform. Resident meetings occur every monthly and the minutes of the last two meetings sighted includes</p>

discussions on food, cleaning, laundry services, activities as well as other topics. All residents speak English. The CCN and RN are able to identify the process for accessing a translator should one be required.

The FM has an open-door policy. All residents and four family members interviewed confirm they have the opportunity to talk to management or staff at any time.

Residents receive adequate information regarding the services they will be provided. All residents (or family) sign a resident agreement which outlines subsidies and services that are provided. The service agreement includes the process for exiting residents from the service and costs of additional services..

There is a process for advising non-subsidised residents of their eligibility and the process to become a subsidised resident should they wish to do so. A copy of the Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is available.

The ARRC contract requirements are met.

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

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

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

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 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

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

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

Attainment and Risk: FA

Evidence:

DOCUMENT REVIEW: The submitted Informed consent policy is comprehensive and well describes the processes relating to informed consent, advance directives, competence, obtaining consent in emergency situations and current NZ legislation.

All seven residents whose record reviewed have a signed admission agreement which includes consents. One of the relatives interviewed advised they would have liked additional time to review the admission agreement prior to signing. Another relative confirmed being provided with 'ample' opportunity to review the agreement prior to signing. The CCM advises the resident and or family are normally provided a copy of the agreement with the information pack for new or prospective residents and given time to review, seek legal advice if required and to sign and return. Additional written consent is sighted for residents prior to having an influenza vaccination and for a resident who has a lap belt in use (as a restraint).

There is a system which allows for the identification of competency and resuscitation status of residents. The system for advance care planning is defined. Advance directives are present in all competent residents' files reviewed during audit. The CCM is fully aware that only competent residents can make advance directives and that family are unable to make this decision. Symbols are used to clearly communicate resident wishes to staff.

One resident is being treated for an infection during audit. The resident is competent in decision making and sighted refusing treatment as has decided that 'I've had enough'. The resident is sensitively informed by the RN of the likely consequences of refusal of this treatment.

Processes are in place to identify who the resident has chosen to make choices on their behalf in relation to welfare and property in the event they become unable to do so. Copies of these documents are obtained and held on file.

Resident choices are generally documented. For example, there are a number of residents who occasionally refuse medication or showers. This is clearly documented in their notes, as are related discussions with the family and or GP when these occur.

The ARRC contract requirements are met.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

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

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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action: Ensure written consent is obtained as required.
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

Attainment and Risk: FA
Evidence:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>DOCUMENT REVIEW: The submitted Advocacy policy describes the role of an advocate and advocacy services and how to access these services.</p> <p>Seven of eight residents (three rest home and four hospital level care) and three of five family members (one rest home and two hospital level care) confirm being provided with information on the Code and advocacy services as a component of the admission process. One hospital level resident and family member confirm being provided with a facility welcome pack but have not reviewed the contents as at audit. The family member of a rest home resident is unaware of what information was provided during admission as another family member was involved with this process. The resident however, confirms being fully informed.</p> <p>Copies of Advocacy brochures are readily available for residents and family members in the facility.</p> <p>All eight residents interviewed confirm they feel well supported by family. The five family members interviewed advise they can come and visit at any time without restriction. Two caregivers and a RN interviewed verify that visiting hours are flexible to meet the resident's needs.</p> <p>ARRC contract requirements are met.</p>

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

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

Attainment and Risk: FA
Evidence:

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

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

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

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

Attainment and Risk: FA
Evidence: <p>All eight residents interviewed confirm they feel well supported by family. The five family members interviewed advise they can come and visit at any time without restriction. Two caregivers and a RN interviewed verify that visiting hours are flexible to meet the resident’s needs. Links with community resources are supported and facilitated. This includes regular reviews of hearing aid functioning. Arrangements for attendance at specialist appointments and the GP are facilitated by staff as required. Staff will accompany residents to health related appointments if family are unable to.</p> <p>Families are encouraged to take their resident out if able. Van trips go into the community weekly as part of the activities programme. The activities coordinator advises attendance is rotated amongst the residents who wish to go. Some residents are able to go out for walks independently and this is observed during audit.</p> <p>ARRC contract requirements are met.</p>

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when 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 1.1.13: 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:

DOCUMENT REVIEW: The submitted Complaint policy clearly describes the complaint management process including timeframes and includes information that complies with right 10 of the code.

Stage two: Complaints forms are easily accessed at the entrance of the service. Brochures about advocacy services and HDC complaints processes are located with the complaints forms. The three of three family and eight of eight residents interviewed report that these forms are easily accessible. A sample of three complaints evidences that the time frames in Right 10 of the Code are met in relation to dealing with, and responding to complaints. The complaints follow up process includes documentation of the initial investigations, outcomes, records the date of letter to the complainant, if the complaint is satisfied, any agencies involvement (eg, advocacy, DHB), further actions taken, when the organisations owner is informed and the complainants right to an advocate.

The complaints register sighted contains details of the complaint, date received, date actions to be taken, date actioned, if advocacy processes have commenced and outcome close off date. The complaints register records 16 reported complaints in 2013, with two of these received through the District Health Board. One complaint received in 2012 was received by the Health and Disability Commissioner. The recommendations related to family communication and the documentation in the residents progress notes are evidenced to be implemented and embedded in practice (also refer to 1.1.9 and 1.2.9).

One of the residents interviewed reports that they have made a complaint in the past and feel that this was dealt with in a timely and effective manner.

The ARRC requirements for rest home and hospital level of care are met.

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

Document review: The site specific Business Plan (2013-2014) for Woodfall Lodge is sighted. It contains Woodfall's vision, mission, values and objectives; reviews the facility's strengths, weaknesses, threats and opportunities; and sets out its proposed strategies and goals. The mission statement and purpose and role of Woodfall Lodge is defined as: 'Quality care with dignity'. The vision for the next three to four years is to: maintain Woodfall's standing within the industry; continue to make small renovation / improvements; Promote Woodfall to the community and fill unoccupied beds.

A pre-audit request was made by the DHB portfolio manager to make comment on the current facility management team (temporary facility manager and the full time clinical nurse manager), to ensure the service is well managed and appropriate for the needs of the older residents at rest home and hospital level of care. As evidenced below and in standard 1.2.2, the Aged Related Residential Care (ARRC) requirements at D17.4b, D17.4ba and D17.5 are met.

Stage two: The service has a temporary manager (in the role since October 2013). The facility manager also manages one of the organisation's facilities in Waipukurau (has managed the other service for two years, that service provides rest home and hospital level of care). The facility manager is onsite at Woodfall Lodge for at least five days a fortnight. The temporary facility manager is a registered nurse (RN) with a current practising certificate (sighted). The temporary manager has completed a management programme through the Hawke's Bay DHB in 2012 (total of 96 hours of education for this programme). The temporary manager has had in excess of 8 hours education related to the management of aged care services in the past 12 months. The training records for the facility manager evidences attendance at ongoing management education through the New Zealand Aged Care Association, employment based issues education and attendance at aged care forums in 2013. The temporary facility manager has completed their performance development recognition programme through the Hawkes Bay District Health Board in May 2013. The facility manager is also a member of Central Hawke's Bay rural nurses support group, which provides 2 hours of education every three months and is currently undertaking post graduate masters level nursing education. At interview the facility manager demonstrates sound clinical knowledge on the care and management of the older person.

The facility manager's job description documents the required qualifications, experience and attributes required for the position. The owner (RN) reports that the temporary manager has annual performance reviews, is suitably qualified and experienced to perform the role of facility manager, feels the temporary manager has very good interpersonal skill and seeks advice when they require this. The facility manager is supported by the Kaylex Care owner (RN) and a full time clinical manager (RN). There are weekly managers' meetings with the organisations other facility managers and the Kaylex Care management team for support and advice (minutes of the Skype meetings sighted).

At interview with the owner, the organisation has plans to employ a full time facility manager at Woodfall Lodge.

The six of six caregivers report that they are supported well by the temporary facility manager and clinical care manager.

The ARRC requirements relevant to rest home and hospital level of care are met.

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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

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

Attainment and Risk: FA

Evidence:

During a temporary absence a suitably qualified and/or experienced person performs the manager's role. The clinical care manager (RN) has been in the quality and management role since May 2012. The clinical manager position description (sighted), includes the purpose of the position and key responsibilities for the clinical care. The clinical manager has more than 15 years' experience as a RN and manager for an aged care facility and the manager of a community health service prior to commencement at Woodfall Lodge. The clinical care manager reports that they feel confident to take on the role of the manager during temporary absences and reports that they have filled in for the previous manager a number of times in the past two years. The clinical manager reports that they are also supported by the owner (RN) and the managers of the Kaylex Care facilities when they have filled in temporary absences. Sound clinical knowledge is observed and demonstrated by the clinical care manager at the time of audit.

The ARRC requirements for rest home and hospital level of care are met.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

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

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:

DOCUMENT REVIEW: The submitted quality and risk plan October 2011 describes the organisation's approach to quality assurance and the current quality goals. This contains references to how staff are engaged in, and kept informed about quality and risk activities (eg, monthly staff meetings and Quality & Risk (Q&R) meetings. The submitted policies contain clear descriptions of how policies, forms, guidelines and any other documents are controlled, (eg, processes for review of documents and management of obsolete documents). Each submitted policy and form shows evidence of being controlled with titles, reference and review dates clearly identified on each page. The submitted Quality and Risk Plan and Strategic Business Plan describe the organisations approach to identifying, documenting and mitigating/managing risks. There is also reference to a risk policy but this was not submitted. Systems and methods include staff training, adverse event reporting and internal audits of all service areas. There is evidence that corrective action plans are developed to identify and address areas of underperformance.

The Health and Safety policy and the Unwanted Events policy and procedures define and describe in detail the management of health and safety matters and all adverse events. There are a range of emergency/ disaster plans and protocols which describe all potential disasters, contingencies and other emergency preparedness protocols including responsibility of staff and staff training.

Stage two:

The Kaylex Care organisation has a quality and risk management system which is understood and implemented by staff, as confirmed at interview with the 10 of 10 staff interviewed. The risk management plan is individualised to the facility's risk. The sighted hard copy register includes the hazard, potential harm, if it is a significant hazard, measures that can be implemented to eliminate or minimise the risk. A process to measure achievement against the quality and risk management plan is implemented. The service has a hazard register and a monthly workplace inspection is conducted to monitor the risks (sighted). When new hazards are identified, a hazard notification form and analysis of the risk is documented. Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. If there are significant hazards, such as an outbreak, notices are placed at the entrance, to inform visitors of the risk.

The Kaylex Care head office develops and implements policies and procedures for Woodfall Lodge. The policies and procedures sighted that are aligned with current good practice and service delivery meet the requirements of legislation, and are reviewed at least two yearly (or sooner if there are changes in legislation or current best practice). The policies and procedures have a version control in the footer. Only the current version of the electronic documents can be accessed by the facility. The head office electronically archives obsolete documents. The facility manager confirms they receive updates when policies are updated and they can only access the current version of the documents.

The annual quality audit schedule sighted for 2013 covers the essential components of the service. The quality audits are conducted at the facility level, and the organisational management team also conducted quality audits at the service. Five internal audits are sampled for 2013.

Quality improvement data is collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, residents. The quality improvement data is collected at the service and analysed and evaluated by the organisational management team monthly. The data is benchmarked with the other facilities within the Kaylex Care organisation. When the quality improvement data falls below the expected benchmark rate, actions are put in place to make

improvements. The results are also tabled at the health, safety and quality meeting and staff meetings. The 10 of 10 staff interviewed report that the quality improvement data and results are feedback to them at the monthly meetings.

A corrective action plan addressing areas requiring improvement in order to meet the specified standard or requirements is developed and implemented. When shortfalls are identified, a quality improvement plan is commenced, and these are reported to the organisational management. The quality improvement action plan format includes evaluation of the shortfall, recommendations, response and review of the implemented actions. If staff training is required, this is recorded in the quality improvement action form and a review is conducted on how the staff training made changes to improve quality

The relevant ARC requirements of rest home and hospital level of care are met.

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: DOCUMENT REVIEW: The submitted Unwanted Events policy and procedures define and describe in detail the reporting, documenting, investigation and overall management of adverse events, including serious and sentinel events.

Stage two: The facility manager interviewed understands the requirements and obligations in relation to essential notification, serious events and sentinel events. The 10 of 10 staff interviewed demonstrate knowledge of when they need to complete the organisation's incident/accident/near miss notification form.

The organisation's incident/accident/ near miss form is used to document adverse, unplanned, or untoward events including service shortfalls. These forms are reviewed in order to identify opportunities to improve service delivery, and to identify and manage risk. The incidents are collected, analysed and evaluated monthly. The central data base of the incident are reviewed and benchmarked with the other facilities in the Kaylex Care group. The analysis of the incidents at Woodfall Lodge records that the occurrence of incidents is below the benchmarking average and no trends have been identified in the rest home or hospital services.

The adverse event report forms sighted for 2013 record the incident, description of circumstances prior to the incident, follow up actions, and how the event is to be reviewed to contribute to improvements. The incidents are reviewed at the health and safety meeting and analysis includes residents who are identified at risk for falls or require further interventions to manage challenging behaviours.

The relevant ARC requirements of rest home and hospital level of care are met.

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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
<p>Evidence:</p> <p>DOCUMENT REVIEW: The provider submitted individual job descriptions for deputy manager/clinical coordinator, health and safety officer, infection control coordinator, restraint coordinator, healthcare assistant, senior care assistant, diversional therapist, cook and kitchen assistants, gardener, handyman, laundry assistant and housekeeper, and receptionist/administration. Each job description includes who the role reports to, overall objectives and responsibilities. The submitted orientation policy describes the service’s timeframes and systems in relation to new staff orientation/induction. The actual content of orientation programmes was not submitted and it could not be determined by documentation review if these include essential components of service delivery (eg, emergency protocols, policy and procedures, confidentiality, training and education) and how these are varied for different roles. The policy states who is responsible for supervising the orientation.</p> <p>Stage two: The staff files of two RNs confirm their professional qualifications are validated, including evidence of registration, at commencement of employment and annually for the staff who require annual practising certificates. A folder is maintained of current practising certificates, sighted for all staff who require an APC (eg, RNs, GPs).The file of the cook evidences safe food handling qualifications. The recruitment process sighted in seven of seven staff files (two RNs, three caregivers, one cook and one diversional therapist) evidence the appointment of appropriate staff to safely meet the needs of the residents. The recruitment process includes application process, interview, reference checking, police vetting and qualification verification. The seven of seven staff files sighted have job descriptions which include code of conduct and confidentiality. Police vetting occurs as part of the employment and recruitment process and the service has now commenced annual police vetting as part of the performance appraisal system.</p> <p>Staff orientation includes training, knowledge of legislation, competency and skills checklist and at least three orientation shifts alongside an experienced staff member. The orientation checklist for the care staff includes orientation to the environment, emergency equipment and procedures, demonstration of safe, competent nursing practice, infection prevention and control, the communications systems (including progress notes, RN communication), medication administration and manual handling. All staff complete an orientation that includes resident dignity and privacy, health and safety and essential components of the service and quality systems. There are specific orientation checklists for catering staff, cleaning staff and laundry staff. The 10 of 10 staff interviewed confirm they had completed the orientation.</p> <p>The service conducts an initial performance appraisal after 11 weeks of employment and an annual performance review. The initial assessment documents if the staff member is meeting the expected organisational standards and summary of overall performance. The seven of seven staff files reviewed confirm the initial appraisal or the annual performance appraisal (as appropriate to the duration of employment).</p>

The service has a system to identify, plan, facilitate, and record ongoing education for staff. The in-service programme sighted for 2012 and 2013 includes the essential requirements of the standards and contractual requirements for rest home and hospital level of care. Sighted education records of attendance and the individual staff records confirm recent education has included infection prevention and control (covering policies and procedures, standard precautions and transmission based precautions in April 2013), restraint minimisation and safe practice (September 2013), fire evacuation (July 2013), first aid training (February and November 2013) and direction and delegation for the nursing staff (October 2013). Care skills education of the past 12 months has included palliative care, continence management, skin care, mobility, falls prevention, wound care and manual handling. The ongoing training plan sighted for 2014 includes mandatory training days that cover the emergency services, infection control, aging process, skin care, rights, direction and delegation, confidentiality, documentation, health and safety, quality process, incident/accident and complaint reporting, medicine management, nutritional and hydration, challenging behaviours, de-escalation and dementia.

Informal education is also conducted that is applicable to the needs of the resident. When the service admitted a resident that required enteral feeding, the dietitian provided demonstration to the staff on the use of the feed pump, nutrition and infection control related to the feed and feeding tube. Reference information on the use of the pump was provided by the dietitian.

The relevant ARC requirements of rest home and hospital level of care are met.

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

DOCUMENT REVIEW: The submitted staff numbers and skill mix policy describes how the service plans to ensure there are an adequate number of suitably qualified staff on duty and lists situations when staff numbers and skills will be evaluated (eg, core business change or resident population change).

Stage two: There is a documented staffing levels policy that ensures staffing levels meet the residents' needs. All staff undertake appropriate education and training to perform their roles. If staff are off work for any reason another person is sought to work the shift. All clinical care is well planned and identified in the seven of seven residents' files reviewed.

The rosters sighted for the previous four weeks confirm that all shifts are covered by at least one staff member who holds a current first aid certificate. Management and staff interviews confirm additional staff are rostered as required to meet residents' needs. The facility manager (RN) is on sight at least five days a fortnight. The clinical care manager (RN) works Mondays to Fridays. The minimum staff levels as confirmed in rosters from September 2013 indicate:

- morning shift: one RN (6.45am-3.15pm) and six caregivers. The caregivers have varying shifts times, which are 8am-4.15pm; 8am-4pm; 8am-3.30pm; 6.45am-.1.30pm; 8am-1.30pm, and 6.45am-12.15pm.

- afternoon shift: one RN (2.45pm-11.45pm) and four caregivers (two caregivers 4pm-midnight, one caregiver 4pm-11pm and one 14.45pm-11.45pm)

- night shift: one RN (11.15pm to 7.15pm) and two caregivers (one midnight-8am, and one midnight to 8.25am).

The activities coordinator shifts are Monday to Friday 0930 to 1600. There are adequate dedicated laundry, maintenance, cleaning and kitchen staff.

The six of six caregivers interviewed report that they are able to perform their required duties in the times allocated. The six caregivers and one RN interviewed report that they are supported well by the temporary facility manager and the clinical care manager. The eight of eight residents and five of family/whanau report satisfaction with the delivery of care. Also refer to CAR at 1.3.7.1 regarding the activities programme.

The relevant ARC requirements of rest home and hospital level of care are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

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

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

Attainment and Risk: FA

Evidence:

DOCUMENT REVIEW: The submitted documentation policy defines and describes procedures for managing health information that meets the requirements of the NZ Health Record standard

Residents' demographic information is entered into a resident register on entry and this is sighted. An admission assessment includes verification and documentation of individual resident information. Review of seven of seven residents' records indicates that they include reports from all health professionals involved in the residents care. However, where the general practitioner documents consultation records on Medtech, copies of these notes are not always present in the resident's notes and this is included in the area for improvement raised in 1.3.3.3.

Progress notes are documented each shift by the caregivers with few exceptions in the seven sampled files. These entries are reviewed and signed by the RN most shifts but at least every twenty four hours in the sampled files. Nursing staff also document in the resident notes where appropriate.

Records are stored in locked cabinets. Staff sighted to be ensuring records are returned to the cabinet when not in use. Archived records of current residents are stored securely in designated cupboards. Historic resident records are stored separately and are reported to be maintained for 10 years as required to meet industry accepted practice.

ARRC requirements are met..

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

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

Attainment and Risk: FA

Evidence:

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

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

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

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

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

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

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

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

Attainment and Risk: FA
Evidence: <p>DOCUMENT REVIEW: The submitted pre-entry screening and entry criteria policy, and resident welcome pack contains clear descriptions of services on offer, referral sources, access, hours of operation and the processes if declining entry.</p> <p>The CCM advises residents are required to be assessed by Support Link as requiring rest home level care or hospital level care even if privately funding care.</p> <p>Adequate information about Woodfall Lodge is provided. The resident information pack includes the mission and values, admission process, rights and responsibilities, management of valuables and property, payment, confidentiality and complaints. The service operates twenty four (24) hours per day seven days per week. Visiting hours for families are flexible (as confirmed in resident/family interviews). The family of two recently admitted residents confirm being provided with the resident information pack. One of the family members has not reviewed the contents as at audit. The other family member advises the information was sufficiently detailed. Following a review of this information, and a visit to this facility (and several others) the resident and family member confirmed selected Woodfall Lodge as being the best fit for the resident.</p>

Seven residents' files reviewed during audit comprising four rest home and three hospital residents. Evidence of the completed admission documents and Support link assessments are sighted for all seven residents. All Support Link assessments sighted confirm the resident requires either rest home or hospital level care.

The ARRC requirements are met. Full details regarding the resident's right to receive additional services, and circumstances in which the agreement can be cancelled is included in the residents' agreement.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

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

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 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

DOCUMENT REVIEW: The submitted pre-entry screening and entry criteria policy contains clear descriptions of services on offer, referral sources, access, hours of operation and the processes if declining entry.

Interview with the CCM advises patients are only declined admission if there are no beds available or if the prospective resident requires specialist dementia care. The CCM advises the prospective resident is advised of options to be wait listed (if they would like). Where prospective residents are declined the applicant and next of kin are informed as well as the referrer and they are informed of alternative providers who may be able to assist.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

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

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 1.3.3: 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; D16.5c.i; 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: PA Moderate
Evidence: <p>Residents' and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. There are processes implemented to ensure all applicable staff and contractors have current annual practising certificates (refer to 1.2.7).</p> <p>All assessments and care plans are developed and reviewed by the CCM (who is a registered nurse) and one other RN who have completed interRAI training. Emails verifying the CCM and RN are competent with interRAI processes are sighted.</p> <p>Daily interventions and support with activities of daily living are implemented with the help of trained caregivers.</p> <p>Timeframes for service delivery are defined. An initial assessment is performed on admission and an initial care plan developed for all residents whose records are reviewed. A long term care plan is developed within 21 days for the six residents who have been in the rest home for longer than this time. Long term care plans are reviewed at least every six months or sooner where indicated. Care plans sampled are comprehensive and include physical, spiritual and cultural abilities, deficits and expected outcomes. Assessments by medical staff are not always occurring in the timeframes to meet the ARRC contract and records related to these assessments are not always available in the resident files. These are areas requiring improvement.</p> <p>Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement including visits from allied health providers. Residents' files are integrated.</p>

Residents retain their own GP on admission. The CCM advises one GP practice is accepting enrolments if the resident is from out of town and does not have a GP already. A GP interviewed advises Woodfall Lodge are responsible for contacting him when residents are due their routine reviews. The GP will attend the facility if required or alternatively if the resident is able they attend the GP rooms. The GP has been providing services for enrolled residents at Woodfall Lodge for over 10 years. The GP confirms being contacted in a timely manner about changes in resident's care needs. Communication will occur between staff and the GP via phone if urgent otherwise via fax. The CCM advises most conversations are followed up with a fax request and these are sighted in the resident files sampled. The GP confirms the consultant haematologist at the diagnostic service identifies ongoing dose requirements for patients who are on warfarin. Copies of laboratory results are sent to the GP rooms and the GP confirms being responsible for ensuring these are followed up. The GP has come to Woodfall Lodge for an unscheduled visit to discuss the results of recent investigations with a resident and plan ongoing care. The GP advises that there is a GP on call until 10 pm at night and for set hours on the weekend. The FM and CCM advise them on call GP is not always able to come when called and if there are any concerns about a resident the resident will be transferred to the DHB hospital.

Shift handovers occur between each shift and assist with ensure continuity of care. During the audit one afternoon handover between the RNs is observed and confirms accurate and comprehensive information is communicated. A separate handover occurs for the caregivers who have a different start time. The six caregivers interviewed confirm they are informed of changes in the resident care needs and other events including falls.

Refer details in criteria 1.3.3.3

The relevant ARRC requirements are met with the exception of D16.5e I 1 and 2.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: PA Moderate

Evidence:

Timeframes for service delivery are defined in policy. An initial nursing assessment is performed on admission and an initial care plan developed. A long term care plan is developed within 21 days in all six (three rest home and four hospital level care) resident files sampled during audit where the resident has been in the facility more than 21 days. Long term care plans are reviewed at least every six months (for residents who have lived in Woodfall Lodge this time) or sooner where indicated. Care plans sampled are detailed and include physical, spiritual, individual and cultural needs and expected outcomes.

There is currently no documentation by the general practitioners to identify that residents have been assessed as stable and suitable for three monthly reviews in variance to the ARRC contract requirements in any of the six residents' files reviewed. The CMM advises there is no process for this to occur although an uncompleted form is present in one of the resident's file reviewed.

Assessments by the general practitioner are not always occurring in the timeframes to meet the ARRC contract. For example; one hospital level care resident has a five month interval between documented reviews in early 2013. Another hospital level resident is noted on the summary timeline to have been seen multiple times by the GP for assorted issues. Copies of the GP records related to some of these assessments are not available in the resident's file. These are areas requiring improvement.

While assessment of resident history, interest and hobbies are obtained, the activities programme does not provide adequate choice for hospital level residents. This is an area for improvement in criteria 1.3.7.1.

Rest Home Tracer:

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

Hospital Tracer:

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

Finding:

- 1) There is no documentation in the sampled residents' files to identify the GP has assessed that the resident is stable and suitable for three monthly reviews (rather than one monthly reviews) as required in the ARRC contract.
- 2) Records are not available to demonstrate that all residents are being routinely reviewed at least three monthly.
- 3) There are a number of GPs providing service who type electronic records following resident review. A copy of some of the GP review notes is not available in some of the residents' files sighted during audit.

Corrective Action:

- 1) Ensure the medical practitioner identifies that residents are stable and suitable for three monthly reviews.
- 2) Ensure that residents are routinely reviewed at the required frequency (as determined by the GP) and that records of all consultations are obtained and included in the resident clinical records.

Timeframe (days): 90 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>Base line observations and weight are also recorded on admission, and there after monthly (or more frequently if required) for six of the seven residents' files sampled. One resident refuses on occasions.</p> <p>Assessments are now being undertaken by the CCM and one trained RN using the interRAI framework. All residents now have interRAI based assessments and care plans in place. The sampled files includes falls risk, pressure area risk, activities of daily living abilities and assistance required, communication needs and individual, social and cultural needs. The results of the assessment process is transferred onto the long term care plan with outcomes and goals documented. All assessments sighted are current and reflect the needs of the residents whose records reviewed. Residents and family interviewed on this topic confirm involvement in the assessment process. Each resident has a single room and this assists with ensuring assessments are conducted in private.</p> <p>There are a range of additional assessment tools available for staff including fluid balance charts, restraint monitoring charts and challenging behaviour assessment forms. Pain assessment forms are not in use and this is an area for improvement raised in 1.3.8.2.</p> <p>Long term care plans sighted have been completed within three weeks of entry in the six applicable files. One rest home resident whose record reviewed has been in the rest home less than three weeks.</p>

The relevant ARRC requirements are 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>DOCUMENT REVIEW: The submitted care plan policy outlines ARRC contract requirements and states "Each resident must have a documented long term plan of care which is updated no less often than every three months and a short term care plan that tracks acute care changes where necessary and which is updated as frequently as required". The CCM advises they have recently changed to ensuring all care plans are routinely reviewed every six months and the policy will be amended during the next review process.</p> <p>A short term care plan is developed on admission in all seven (four rest home and three hospital level care) residents' files sampled. A long term care plan is developed within three weeks for the six sampled residents who have been in the facility this period of time. The long term care plan is developed by the CCM or one other RN who has completed interRAI training. The care plans includes goals and interventions for identified medical needs, personal hygiene/activities of daily living needs, mobilisation needs, skin integrity/pressure prevention, breathing, pain, nutrition/ fluid needs, rest/ sleeping requirements, cultural needs, behaviour and cognition. Interventions sighted are consistent with assessed need and good practice. The required level of dependence and independence is documented for all components as a narrative report. Current long term care plans are sighted in the six applicable residents' files.</p> <p>Short term care plans are developed when required. A number of short term care plans are sighted within the sample. For example, for the management of infections and</p>

for wounds. Most short term care plans are reviewed regularly and closed out when discontinued. Some exceptions are noted and this is raised as an area for improvement in 1.3.8.2.

Residents' files sampled evidence integration and includes progress notes, correspondence, medical notes, adverse events/incidents, laboratory results, Support Link correspondence, DHB letters and medical specialists records. Staff interviewed confirm they have access to residents' records and were sighted completing their progress notes on the day of the audit. Copies of the admission agreements are held in a separate file.

ARRC contract requirements are 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

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

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:

Required interventions are documented within the care plan. Interventions sighted are commensurate with the desired goals and identified care needs of all of the resident's. Interventions are detailed and documented clearly to guide staff in care provision This is verified during interview with six of six caregivers. Residents are encouraged to be involved in developing realistic and optimal levels of functioning to meet their own everyday living needs/goals and to maintain independence (as much as safely possible). One resident wanted to use the bedside table for support and mobilise independently around the bedroom. The resident advises staff would not allow this. The resident's family member confirms the resident has had a number of falls prior to and following admission and is not safe to mobilise independently. Staff will assist/supervise the resident mobilising in the bedroom and also out in the corridor (sighted) and mobility devices are used.

Short term care plans are required when a specific problem is identified and the required interventions are documented. One resident's file sampled contains short terms care plans for three infections in recent months. Short term care plans for infections also sighted in other resident files reviewed. Short term care plans for wounds and skin tears also sighted in sampled files.

Records of fully implemented and monitored interventions are sighted in the remainder of the sample.

The relevant ARC requirements are met. Residents are treated with respect and dignity. Privacy and cultural requirements are documented within care plans (if identified).

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: PA Moderate

Evidence:

Completed activities assessments are sighted in the files of all six residents who have been in the facility more than 21 days. The activities assessment includes a review of the resident's interests/hobbies and ability. A weekly activity plan (Monday to Fridays) is developed and a copy given to each resident. The activities provided for hospital level residents do not encourage resident participation as the activities are more applicable to more physically able residents. This is an area requiring improvement.

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: PA Moderate

Evidence:

DOCUMENT REVIEW: The submitted activities policy states 'On admission the Activities coordinator/RN will sit with the resident's first Emergency Contact/P.O.A. and discuss their interests/hobbies and complete a questionnaire. The information provided will enable the Activities Coordinator to formulate a Care Plan which will ensure a balance of activities both indoors and outdoors and encourage the resident's relatives to be involved where possible. The Activities Coordinator will review this plan at least every 6 months but it could be sooner as the needs of the resident changes.'

Completed activities assessments are sighted in the files of all six residents who have been in the facility more than 21 days. The activities assessment includes a review of the resident's interests/hobbies and ability.

There are two activities coordinator who facilitate the activities programme. One (a qualified diversional therapist) works Monday to Wednesday inclusive. The other activity coordinator works Thursday and Fridays.

A weekly activity plan is developed and a copy given to each resident. This process is sighted during audit and is verified by all residents and three family members interviewed as consistently occurring.

The activities programme includes three identified activities per day. Resident birthdays are celebrated. Two activities are scheduled in the rest home and occur between 10.30 and 3 pm weekdays. The final activity is held for Hospital residents between 3pm and 4pm (although hospital residents are welcome to attend activities in the rest home). The activities for hospital level residents are noted as making Christmas decorations, music, cooking, art and games. The activities programme for hospital level care residents has only commenced in the six weeks prior to audit. The activities provided for hospital level residents do not encourage resident participation as the activities are more applicable to more physically able residents. Four of the five hospital level care residents interviewed advised they did not attend many activities as they could not participate or did not like the activity. This is an area requiring improvement

The rest home activities are newspaper reading, tai chi, basketball, decorating the Christmas tree, baking, reading, housie, an entertainer, drives out (weekly) and bocce.

The family of the newest resident sighted bringing the residents cat in for a visit. This delighted the resident.

Another resident is sighted completing craft activities as this is an interest. Residents sighted with a personal television in their room and a number have a radio or stereo.

The Salvation Army comes in monthly and undertakes a church service. The Anglican Church also provides a monthly Church service on site. The activities coordinator, RN and two of two caregivers interviewed advise attendance in all activities is voluntary.

Finding:

An activities programme for hospital level care residents has commenced in the last six weeks. There is one hour of activities scheduled weekdays afternoons specifically for hospital level residents (although some residents do attend some of the rest home activities). The activities provided for hospital level residents do not encourage resident participation as the activities are more applicable to more physically able residents. Residents interviewed advised they did not attend many activities as they could not participate or did not like the activity.

Corrective Action:

Ensure the activities programme is appropriate to the service setting and needs of hospital level residents

Timeframe (days): 90 (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: PA Moderate

Evidence:

There are processes in place to facilitate evaluation of care and the resident's progress in meeting the care plans and goals. Evaluations are occurring but are not always sufficiently documented and this is an area requiring improvement.

One resident is being provided with enteral feeds which are documented as administered on the medication charts. The service is unable to evidence that the water bolus of 150 mls is administered three times a day as prescribed and this also requires improvement. The RN advises this will have been administered but not documented

ARCC contract requirements are met.

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: PA Moderate

Evidence:

Evaluations of residents progress towards meeting their care plan and goals is occurring and verified in all relevant files at audit.

Evaluations are not always sufficiently documented in resident files sampled. For example:

- adjustments are being made to a resident's pain management medications converting oral morphine elixir to slow release tablets. Whilst the RN reports the Abbey pain scale is available a pain assessment tool is not being used to objectively monitor the impact of changes. The resident confirms being provided with additional pain relief on request.
- a resident has a wound care plan developed for a skin tear. There is no documented evaluation of the wound at all since the plan was developed
- one rest home resident audited is on insulin. There are some evaluations noted by the RNs about individual episodes of high blood glucose levels (BGLs). There is no overall analysis of how the resident is meeting the intent of the care plan in relation to diabetes management.
- there is a separate column in the progress notes to monitor resident's bowel functions. This is completed well for some resident's and intermittently for other resident's.
- while wound care is noted as being provided for a resident with complex needs (with the support of the DHB wound care RN); evaluations of the wound are not always documented when dressings are changed. On some occasions the RN undertaking the wound care notes a detailed description of what the wound looks like. On other occasions the RN has noted 'wound redressed' or similar comment only.

Short term care plans sighted for when residents have urinary or other infections. The required interventions are noted. Evaluations are documented detailing how the resident has responded to treatment and all infections have been resolved.

Checks of residents' weights and blood pressure (BP) and pulse occur monthly in five of the seven residents' files sampled. One resident has not been in the facility for a month. The other rest home resident is noted to refuse some of the checks.

One resident is requiring enteral fluid and nutrition and the regime is noted on the medication chart. Not all required doses of water are signed as given.

Interventions are provided to meet the changing care needs of residents. Examples sighted during audit include identification and treatment of suspected infections, management of episodes of high and low blood glucose levels, provision of pain relief when required, and assistance with stoma care. One resident is scheduled for a surgical procedure imminently and a resident is being provided with enteral nutrition. One resident is being cared for in contact precautions after developing diarrhoea associated with antibiotic use. A pressure relieving mattress and cushion were provided to a resident with a high risk of developing a pressure injury. The resident disliked the products and refused to use as verified at audit in interview with the resident and family member.

Finding:

Evaluations are not always occurring or are sufficiently documented in residents' files sampled.

Corrective Action:

Ensure evaluations are sufficiently documented to identify the effectiveness of care provided and/or progress to achieving the desired outcome.

Timeframe (days): 90 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

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

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

Attainment and Risk: FA
Evidence: <p>DOCUMENT REVIEW: There is a submitted resident referral policy that describes all situations where referral to other services may be necessary and how these are authorised. The policy states 'All referrals will be documented in the resident's file with the reason why the referral was made, date of appointment and outcome of appointment. When the appointment is off the grounds, a member of staff will accompany the resident if a family member is unable'.</p> <p>The GP interviewed states that resident support for access or referral to another health and disability provider is facilitated in a timely and safe manner. The GP confirms his involvement in the referral process.</p> <p>The CCM states that a formal referral process exists which includes the identification of risk and discussion with the resident and or family. One resident has refused referral for ongoing investigations. The discussion and context are noted in the resident file. One resident has a complex wound and is receiving care from the DHB specialist and wound care nurses. The patient is scheduled for imminent surgery.</p> <p>A representative from the hearing association is present during audit to check all applicable residents who have hearing aids. The check includes fit and batteries. The CM is sighted advising the representative of the names of new residents or residents with new hearing aids or who have reported concerns with how their hearing aid is functioning.</p> <p>Residents interviewed state they have access to the community health services of their choice and have retained their own GP.</p>

The ARRC requirements are met.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

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

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

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: <p>DOCUMENT REVIEW: The submitted exit, discharge and transfer policy & procedure states "A comprehensive discharge plan is drawn up informing the receiving agency or allied support staff of the needs of the resident".</p> <p>There is open communication between staff and family relating to all care provided including transfer. The RN phoned the family of a resident during audit to advise of specific events which had occurred. The resident was subsequently transferred to the DHB hospital as the GP was unable to come and review the resident immediately. The resident's next of kin were phoned again by the RN and advised of the resident's decline in condition and subsequent transfer to the DHB hospital and this telephone conversation was observed. The three family members interviewed on this topic confirm they are kept well informed by staff.</p> <p>One resident has an appointment with medical specialists at the DHB in preparation of imminent surgery. The RN has completed a nursing care summary detailing this residents care needs to ensure the specialists are informed about the resident and level of cognition and functioning. The summary notes the resident is incontinent, how the resident identifies pain levels, where the pain is being reported and that contact precautions are required for an identified infection. Vital signs are checked and recorded including the resident blood glucose level. Changes (made by the GP) to the resident's medication since the last specialist appointment are also noted on the form.</p>

The GP interviewed confirms his involvement in the discharge/transfer process. The CCM advises in the event of a discharge or transfer to another facility the resident's records would be copied including the current care plan, medication chart, medical records, advanced directives, next of kin details and other relevant data would transfer with the resident.

The ARRC requirement is met.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

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

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

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: PA High
Evidence: <p>Policies and procedures detail how medications should be managed. Twelve medication charts are reviewed and demonstrate medication reconciliation is occurring, allergies are documented as being assessed and medications are reviewed in the last three months by the GP. Areas for improvement are identified in relation to medication prescribing/transcribing, refrigerator medication storage, ensuring medications are administered as prescribed or noted to be refused or withheld. Ensuring controlled drugs are managed in accordance with legislation is also an area for improvement.</p> <p>The RN was observed undertaking a breakfast medication round. The RN is observed informing the resident of what medications are being administered at the time. One rest home resident interviewed is able to describe that recent changes in medication have related to replacing morphine elixir with a slow release tablet. The three family members interviewed on this aspect confirm being advised if there are any changes being made to medications or new medications started (eg, for infections).</p>

The policy details the process for self-administration of medication. One resident is self-administering insulin (after the RN has dialled the correct dose as the resident now has a significant vision impairment). The resident confirms during interview to being 'perfectly capable' of administering the insulin but confirms no longer being safe to identify the dose. The resident's care plan details that the resident has been assessed as safe to self-administer medications and the process is detailed.

There is a process implemented to ensure that nursing staff and caregivers are competent for medication administration. Completed competencies are sighted by the lead auditor for all eight RNs including the CCM and four caregivers. The competency includes oral medications and insulin.

Records are also sighted by the lead auditor verifying nursing staff have been provided with training on enteral feeding and management of infusion pumps (for palliative care).

ARRC contract requirements are met excluding D15.3c and D19.2d.

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: PA High

Evidence:

DOCUMENT REVIEW: The submitted medicine management policy describes each stage of medicines management and administration and the provider's staff responsibility is described. Medicine policy describes assessment process for determining self-administration.

During audit 12 medication charts are reviewed. All have been recently re-written by a RN and provided to the applicable GP for review and signing. The CCM advises she reviewed this process prior to transcribing the medications and provided a summary of information provided by the New Zealand Nurses Organisation (NZNO). The start dates noted are the dates the medication chart was rewritten and not the date the medication actually commenced. Whiteout is used on some of the charts to remove columns to enable the pro re nata (PRN) indications to be documented without lines present. These aspects do not meet current accepted practice and require improvement. The GP interviewed advised the medication charts are reviewed prior to being signed. All medication charts reviewed demonstrate three monthly reviews have occurred in the last three months. Allergies are consistently being recorded. Medication reconciliation is occurring.

Some medication is being stored in the fridge. While there is regular monitoring of the refrigerator temperature this is not within the required parameters. It is noted to be outside of the required temperature range most days in November with a temperature as low as minus three degrees Celsius recorded. There is no evidence of review or remedial action and this requires improvement. The thermometer is sighted to be positioned directly under the ice box when sighted during audit.

Medications are stored in a locked room. The key is sighted being carried by the RN. Medication is delivered in Robotic packs. The FM and CCM advises recent changes have been made in the pharmacy providing services.

Medication is delivered monthly in two week robotic rolls. The CMM personally reviews each medication roll and prescription on arrival to ensure the contents align. This includes the first full day's medication and the first weekly or monthly medication to ensure all is correct. Where additional medications are subsequently prescribed this information is faxed to the pharmacy and a supplementary robotic pack delivered. Where medication are discontinued or the dose changed a new robotic roll is delivered

for the patient. All unwanted medications are returned to the pharmacy in a designated container. Unwanted or expired controlled drugs are signed as being returned to the pharmacy. Not all regular prescribed medications (eg, lactulose and inhalers) are signed as given or noted as withheld or refused. For example, a resident is not documented as receiving respiratory inhalers as prescribed. Only 42 doses out of 60 due are signed as administered in October 2013. Another resident is charted lactulose '20 mls BD'. This is not being given or noted as refused or withheld and this is an area requiring improvement..

A controlled drugs register is maintained. Weekly checks of the balance are occurring. A six monthly quantity stock count has also occurred and records are sighted. One resident is noted to have refused a dose of 10 mg M-eslon. There is no documentation available to evidence what happened to this tablet. It was not returned into the CD register or documented as being returned to pharmacy. This also requires improvement.

The RN was observed undertaking a breakfast medication round. The RN verifies the identity of the resident using the photograph on the medication chart and that the content of the robotic pack aligns with the medication record. The RN signs for administration after observing the resident has taken the medications. The RN is observed informing the resident of what medications are being administered at the time.

Finding:

- 1 Nursing staff are transcribing medications on charts for review and signing by the medical practitioners when the current chart in use requires rewriting. The date that is being noted is the date the medication chart is rewritten and not the date the medications commenced.
- 2 'White out' is noted used on medication records to remove column marks and enable indications for use to be documented without lines.
- 3 The refrigerator that is used for the storage of medication is noted to be outside of the required temperature range most days in November with a temperature as low as minus three degrees Celsius recorded. There is no evidence of review or follow-up
4. Not all regular prescribed medications are signed as given or noted as withheld or refused. A resident is documented as receiving respiratory inhalers only 42 doses out of 60 prescribed doses in October 2013. Another resident is charted lactulose 20 mls BD and is not being given. 5 One resident is noted to have refused a dose of 10 mg M-eslon. There is no documentation available to evidence what happened to this tablet. It was not returned into the CD register or documented as being returned to pharmacy.

Corrective Action:

Ensure all components of medication management meet legislative requirements and current accepted practice.

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

DOCUMENT REVIEW: The submitted nutritional and safe food policy covers all aspects of menu and food planning, procurement, storage, temperatures, preparation, staff training, kitchen cleaning and hygiene and safe chemical use.

There is a four week menu in place. The summer menu is in use. The menu has been reviewed by a dietitian and records sighted dated 17 October 2011. The main meal is provided at mid-day.

Nutritional assessments are completed on entry to the service. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. The records sighted in the kitchen is congruent with the residents' files sampled and resident interviews. There are diabetic menu choices and one resident requires a renal diet. Guidance for the staff is noted in the kitchen

One resident is being provided with enteral feeds which are prescribed and documented as administered on the medication charts. The service is unable to evidence that the water bolus of 150 mls is administered three times a day as prescribed. This is included in the area for improvement in 1.3.12.1. The RN advises this will have been administered but not documented.

Five out of eight residents interviewed are very satisfied with the food being provided. The rest home resident audited finds the dietary requirements (for diabetic and renal diet) very restrictive and admits to not always conforming. The hospital resident audited requires puree meals (which are provided). The resident advises the quantities served at breakfast and lunch are sufficient. The resident advises to requesting a second serving some evenings and this is provided at request. Another resident interviewed was 'not fussed' with the lunch meal as the 'fish is too chunky and white'. The resident confirms if an alternative meal is requested this is provided.

The kitchen is sighted to be clean and tidy. There is monitoring of the temperature of the fridge and freezers which are within the required range. Recipes for dishes on the menu are sighted. Dry goods are stored in canisters. Food is sighted in the refrigerator covered and dated. The cook has completed food hygiene training as sighted by the lead auditor.

ARRC contract requirements are met.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

DOCUMENT REVIEW: There is a submitted waste management-general waste policy and a waste management-hazardous substances policy. Both policies adequately describe the systems and methods for managing kitchen, isolation, continence products, single use medical equipment, dressing and wound products (eg, cardboard, paper hand towels, tissues, resident's room rubbish-bins, sharps, infectious, and contaminated waste). The submitted civil defence manual provides descriptions of, and emergency response systems for Woodfall Lodge. The manual states its purpose is 'to provide a plan of action and guide for responding to any event which disrupts the normal operation of the Home, and to assist us to prevent, prepare for, and recover from the effects of both natural and man-made hazards'. It includes guidelines and emergency contingencies related to waste and chemical spills.

Stage two; The above policies and procedures are implemented as observed at the onsite audit. The chemicals are observed to be securely stored in the laundry. The laundry worker and cleaner interviewed report that they 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. There is appropriate personal protective equipment (PPE) and clothing in the laundry, sluice and cleaning areas. The laundry worker/cleaner interviewed report that they have had training in the handling of waste or hazardous substances, last conducted by the external chemical provider in October 2013 (17 staff attended the training).

The ARC requirements are met.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>The building warrant of fitness expires 25 May 2014.</p> <p>Equipment is maintained to ensure safety. Electrical tag and testing was last conducted in February 2014. The calibration of the medical equipment is last conducted in January 2013 (includes hoist, scales, nebuliser, electric beds, sphygmomanometers, thermometer and regulator). The service has a planned and reactionary maintenance programme, with the building maintained in an adequate condition appropriate to the age of the building. The maintenance log notes area of work required, a priority rating (eg to be done immediately, as soon as possible or within four days), and is signed off when the work is completed.</p> <p>The fittings and furniture installed are maintained to ensure safety and the needs of the rest home and hospital level of care residents. The physical environment is appropriate for the residents. Hand rails are installed in corridors. There is disability access at all entrances. The residents' rooms sighted are personalised with the resident's possessions. Some rooms have direct external access, with safe and accessible external areas off the lounge and living areas.</p>

Hot water temperatures in resident areas is monitored monthly. The temperatures sighted are within the safe temperature guidelines for aged care. The facility manager reports that tempering valves are installed to maintain the hot water temperatures.

The ARC requirements for rest home and hospital level of care are met.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>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 the residents. Two of the residents' rooms have full ensuites, with shower, toilet and hand basin. There are an additional 13 toilets and six bathrooms, with one of these bathrooms having a bath, and all others with a shower, basin and toilet. The toilets and showers are clearly identified with signage. The toilets have engaged/vacant privacy locks (also refer to CAR at 1.1.3). The bathing and showering facilities sighted have wall and floor surfaces that are maintained to a standard to provide ease of cleaning and compliance with infection control guidelines.</p> <p>The eight of eight residents and five of five family/whanau report satisfaction with the toilets and shower facilities.</p>

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: All rooms are single occupancy. The rest home and hospital sections are in different wings of the facility. The resident rooms sighted in both the rest home and hospital sections are of a suitable size for the needs of the resident. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid within their room. As observed at the time of audit residents in motorised and un-motorised wheelchairs are freely moving around the facility. The eight of eight residents and family/whanau report satisfaction with their rooms.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: There are lounge and dining areas in both the rest home and hospital sections of the service. The rest home has one lounge, one conservatory sitting area and two dining rooms. The hospital section has one lounge and one dining room. All lounge and dining areas are separated and activities in these areas do not impact on each other. The resident rooms also have facilities for family/whanau if the resident wishes to entertain in their room. The eight of eight residents and five of five family/whanau report satisfaction with the lounge and dining facilities

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

DOCUMENT REVIEW: The submitted waste management policies, housekeeping procedures, and laundry policy contain adequately detailed procedures.

Stage two: The external chemical supplier conducts a monthly surveillance of the cleaning and laundry processes and sends this report the services head office. The cleaning and laundry staff interviewed report they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The laundry and cleaning equipment observed at the time of audit is stored in safe and hygienic areas. The family satisfaction survey, last conducted in July 2013, indicates that 93% of the respondents rate the laundry service as very good to good and one respondent indicating it is fair. The family satisfaction survey results for the cleaning indicate that 93% of the respondent indicate that it is very good to good and one respondent that rated the cleaning as poor (this respondent did not comment about what they felt was poor in the cleanliness of the service, this reflects a one off response and not a systemic issue). The seven of the eight residents and five of five family/whanau report satisfaction with the cleaning and laundry service. One resident reports overall satisfaction with the cleaning and laundry, though did comment that sometimes they felt the linen was a bit 'raggedy' and the windows could be cleaned better. This resident did report that if they are unsatisfied with the condition of the linen, then it is replaced.

The ARC requirements are met.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>DOCUMENT REVIEW: The submitted civil defence manual describes all potential disasters, contingencies and other emergency preparedness protocols including responsibility of staff and staff training. The submitted security policy contains clear and adequate descriptions of security protocols and responsibilities.</p> <p>Stage two: The service has adequate emergency supplies in the event of an emergency or outbreak. There is food and fluid onsite for a minimum of three days' supply. The service has a rain water storage tank. There is a civil defence kit with additional food, first aid and emergency supplies. In the case of mains failure the service has access to a generator and have their own supply of gas and portable cooking equipment.</p> <p>All resident rooms, bathrooms and lounge areas have a call bell system installed. The call bell system has an audible alert, a light that comes on above the door if the call bell is activated and panels in both the rest home and hospital nurses' station that indicate the room. Four of the eight residents and four of the five family/whanau report that the call bell is answered in a timely manner. The remaining residents and family report they felt that it can be slow at times for the call bell to be answered, with one of these residents reporting that it took up to 20 minutes to have their call bell answered. The call bell test at the time of audit had an immediate response from the staff. A corrective action request is made at 1.4.7.5.</p> <p>The orientation and ongoing training records sighted evidence the staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. This includes fire safety and emergency procedures, with the last evacuation drill conducted 31 July 2013. The 10 of 10 staff interviewed demonstrate knowledge on responding to emergency situations. There is at least one staff member on duty at all times that has a first aid qualification.</p>

The approved evacuation plan is dated 21 August 2002. This is an amendment to the evacuation scheme approved dated 21 October 1997.

The service identifies and implements appropriate security arrangements relevant to the residents at rest home and hospital level of care. The afternoon staff are required to close and lock the external windows and doors before it gets dark. The service has three entrances to the service, and in the evening two are closed and residents and visitors are asked to come and go from the main entrance after hours. The six of six caregivers interviewed report that they feel safe and secure when working afternoon and night shifts. The eight of eight residents and five of five family/whanau report they feel safe and secure at night.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: 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 1.4.7.4 (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:

All residents' rooms, bathroom and lounge areas have a call bell system installed. The call bell system has an audible alert, a light that comes on above the door of where the call bell is activated, a panel in both the rest home and hospital nurses' stations that indicates the room. Four of the eight residents and four of the five family/whanau report that the call bell is answered in a timely manner. The remaining residents and family report they felt that it can be slow at times for the call bell to be answered, with one of these residents reporting that it took up to 20 minutes to have their call bell answered. The call bell test at the time of audit had an immediate response from the staff. A corrective action request is made to ensure the call bell system to request assistance is responded to in a timely manner.

Finding:

Four the seven residents interviewed report their call bells are not always answered in a timely manner.

Corrective Action:

Ensure staff response to the call bell system to request assistance is conducted in a timely manner.

Timeframe (days): 180 (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: <p>Areas used by residents and staff are ventilated and heated appropriately. The rest home wing has central heating and the hospital wing has under floor heating. All resident rooms and resident areas sighted have at least one window of large proportion to provide adequate natural light and ventilation. The internal environment is monitored for temperature. If residents required additional heating, the service has electric heaters available. The eight of eight residents and five of five family/whanau report satisfaction with the natural light, ventilation and heating.</p> <p>The ARC requirements are met.</p>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

DOCUMENT REVIEW: The submitted restraint minimization and safe practice policy includes clear definitions (including enablers), with enablers described as voluntary and the last restrictive option. The policy contains definitions and processes that describe how it will meet its responsibilities as specified in NZS 8134.

Stage two: The six of six caregivers interviewed demonstrate understanding that enabler use is voluntary and the least restrictive option. The caregivers report that are no current residents with enabler use and one resident is assessed for the use of a lap belt, though they report that over the past month the restraint use has not been required for the resident. The restraint coordinator (RN) confirms that there are no residents who require the use of enablers and if enablers are to be used it is for resident safety and security and to maintain independence.

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 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

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

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

Attainment and Risk: FA

Evidence:

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. The file of the one resident approved for restraint use records the organisation's policies and procedures are implemented in the approval process. The restraint approval process includes consent for the use, which is approved by the RN, GP and family. The consent, signed by the daughter, RN and GP for the one resident with restraint use records that the safety belt is used while the resident is in a chair or commode, preventing them from falling.

The care plan sighted for the resident with restraint use records that the focus of the use of the restraint is to prevent injury as a result of falls. The lap belt is to be applied as a last resort and for the least amount of time. The restraint coordinator reports that the lap belt is used minimally.

The ARC requirements are met.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint 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 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator reports that restraint is only put in place following appropriate assessment which includes exploring alternatives to restraint or enabler use by identification of triggers, health problems, medications, physical, social or environmental issues. Assessment also considers risk and benefits of restraint or enabler use, such as, will it compromise the wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm, and is there a balance between independence and protection.

The file reviewed of the one resident assessed as requiring restraint identifies that assessments were undertaken in July 2013. Assessments are completed by the restraint coordinator or RN. All restraint assessments are updated at least six monthly and all restraints are reviewed at least six monthly through the health, safety and quality meeting. The six of six caregivers interviewed have an understanding and implement alternatives to restraint, such as low beds, behaviour management and antiroll mattresses, whenever possible.

The ARC requirement is met.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The restraint coordinator reports that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is to be monitored according to risk and a restraint register is maintained.

At the time of audit, bed side rails and safety lap belts are the approved restraints. Restraint planning and application of restraint is undertaken only if the assessment process indicates the use of restraint would be appropriate. Frequent falls by individual residents will often generate commencement of assessment processes and all alternative methods of keeping the resident safe are identified.

The restraint assessment for the one residents with restraint are monitored according to assessed risks but at least half hourly checks are undertaken and signed for by staff using a specific form which identifies if any cares are given.

Restraint is documented in the resident's file and in the restraint register (sighted). The register records the resident's name, type of restraint, when commenced and date discontinued. All restraint is consented to by the family/whanau.

The ARC requirement is met.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

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

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

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

Attainment and Risk: FA
Evidence:

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

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA
Evidence: <p>The restraint coordinator reports that all restraint and enabler use is evaluated at least six monthly as part of the resident review process. The one resident who is assessed for restraint use is not yet due for the full evaluation of restraint use (due January 2014). The organisational evaluation process for restraint use includes family/whanau and resident input as appropriate. The template for the review and evaluation of restraint includes all the points of the standard. Restraint reviews are reported and discussed at the health, safety and quality meetings and types of restraints in use are monitored by the restraint coordinator. The care plan of the one resident with restraint use is congruent with assessment findings.</p> <p>The ARC requirement is met.</p>

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

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

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 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:

The restraint monitoring form for the resident with restraint use records 30 minute checks to ensure the safety and rights of the resident are not compromised. The monitoring form records measures taken to minimise the effects of restraint. The observation records interventions, such as walks, pressure area care, change of environment, personal care, foods and fluids given or recreational therapy. The monitoring form records the staff observations on comfort, psychological and physical effects. The monitoring forms of the one resident assessed as requiring restraint records the 30 minute observations.

The service conducts a six monthly review and evaluation of the restraint use. This includes all points of the standard. The one resident with restraint use has had this for less than six months and is not yet due for the evaluation and review. There has been no other recorded restraint at the service. The monthly health and safety meeting includes a report on restraint use (sighted in the minutes).

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:

DOCUMENT REVIEW: The submitted infection control guidelines and manual state 'We have given clearly defined and delegated authority to an infection control co-ordinator who will be responsible for: Development of infection control policies and procedures which meet the needs of the institution; Staff and Resident Education; Surveillance of infection; Linking infection control risks with risk management programme and any other relevant documentation; Complying with the requirements of Infection Control Standard NZS 8142'. It also states 'The co-ordinator facilitates a quarterly infection control meeting at which infection control issues are presented to and discussed with staff'. There is a separate job description for the co-ordinator which further defines the role. The manual on prevention and management of staff infection states 'Our staff are educated as to the risk they impose by bringing possible infections into the workplace. Our residents are potentially vulnerable to infection and as such we have a wellness policy that encourages staff to be open about any illness they suspect may cause residents to be at risk'. There is distinct reference to the risk of visitors introducing infection in the infection policy and the resident welcome pack also alerts visitors and family to risks of transferred infections.

There is a separate job description for the co-ordinator which further defines the role. The CCM interviewed advises she has not as yet signed the position description (since the previous facility manager left), however is able to clearly identify the role and responsibilities and confirms in interview she is responsible for the IC role. This includes:

- ensuring adequate personal protective equipment (PPE) is readily available
- attend the three monthly IC forums
- discuss IC issues at staff meetings. Discussions sighted in staff meeting minutes reviewed
- oversight of wound management activities
- facilitating and evaluating the surveillance data
- communicating key issues to the manager and resident/family as appropriate

The H&S committee meets monthly and has the responsibility for IC. Minutes of the recent meetings evidences discussions are occurring on relevant topics.

The IC programme is dated 2012/13. The IC programme is noted as having been reviewed by the acting facility manager in the last six weeks. The acting facility manager advises the programme is the same as that currently in use in the other facility that she has management responsibility for.

The four caregivers interviewed are able to identify their responsibilities for preventing the spread of infection. This includes hand hygiene practices and implementing standard precautions. One resident is being cared for with specific precautions as the resident is currently unwell and incontinent. Two residents have a multi-drug resistant organism (MDRO). Personal protective equipment (blue aprons and gloves) and hand hygiene are used during personal cares. Yellow linen bags are used for the used linen of these residents. One resident with a MDRO has been transferred to a room with an ensuite room in June 2013 when the room became available. The CCM advises there have no outbreaks since her employment in April 2012.

Waterless hand gel is sighted available to staff and visitors throughout Woodfall Lodge.

Residents are offered annual influenza vaccinations as verified in records sampled.

ARRC contract requirements are met.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

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

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

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

Attainment and Risk: FA
Evidence:

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

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

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: <p>The CCM advises she can contact the MidCentral DHB infection prevention and control team for advice if required. The GPs, pharmacists and laboratory can also be contacted for any infection control issues. Examples of communications with the GP are sighted in sampled files when residents are suspected of having an infection.</p> <p>The CCM advises a Norovirus outbreak was reported in the Fielding community in the last three months and the public health service provided information on prevention strategies. Copies of resources (posters) to alert visitors and families to the outbreak and to not visit if unwell was also provided by the public health service. The need for thorough hygiene practices were discussed with residents.</p>

ARRC contract requirements are met.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

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

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 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: <p>The organisation uses an infection control manual that has been developed by an external consultant. The manual is dated as being issued in 2009. The manual contains all required policies and procedures to meet the standards. Copies of a number of policy updates are sighted dated 2012. This includes management of pandemic influenza in residential care, infection control orientation guide and management of outbreaks.</p> <p>A wall flip chart that provides easy reference for staff on managing residents with:</p> <ul style="list-style-type: none">- Extended spectrum beta lactamase (ESBL) producing organisms- Clostridium difficile- Vancomycin resistant enterococci (VRE)- Methicillin resistant staphylococcus aureus (MRSA)- Influenza- Gastroenteritis- Scabies (sighted). This is dated as issued in 2013 and is referenced.

There is a wound management folder that is noted as being 'the essential guide to assist clinicians in the wound management decision making process'. It includes easy reference for staff on wound healing and pressure prevention, infections, as well as resources to assess and report wounds.

Two caregivers and a RN interviewed advise they refer to the flip chart for advice if required.

ARRC contract requirements are met.

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.)*

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The previous manager attended the three monthly infection control meetings held with an independent consultant in Palmerston North and records of this are sighted. The CCM advises she will be attending the next meeting which is not scheduled until 2014.

The facility manager advises she attends the Hawke's Bay DHB IC meetings on a monthly basis. Records to verify this are reported to be kept at the other facility she manages.

The CCM attended an in-service education in 2013 on infection prevention and control provided by the prior facility manager and records are sighted.

Resident education has occurred on hand hygiene (as part of Norovirus prevention focus). Information on infection control issues is also included in the information provided to new residents at admission (Refer to 3.1).

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

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

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 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:

DOCUMENT REVIEW: The submitted standardised definitions are clear and comprehensive.

The resident infection surveillance programme includes:

- eye infections
- urinary tract infections
- skin and soft tissue infections
- diarrhoeal disease
- lower respiratory tract infections
- multi-drug resistant organisms

Caregivers interviewed confirm they are responsible for reporting the RN signs and symptoms of infections. The staff can identify what symptoms they would communicate. The RN on duty is responsible for undertaking assessments and seeking treatment where applicable. The CCM is responsible for maintaining the infection register, analysing rates and communicating the results to staff and management.

Infection rates data is reported monthly and is reported separately for rest home and hospital residents. Four caregivers interviewed on this topic confirm they are well informed including at shift handover when a new resident infection is suspected or identified. This communication is observed during audit and in meeting minutes sighted. The infection data sighted at audit includes all the infections noted in the sampled residents' files with one exception. The owner stated she undertakes benchmarking of infection rates with the other two facilities she owned and benchmarked data is sighted. The owner has noted analysis of variances from month to month and between facilities.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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