

St Clair Park Residential Centre Limited

Current Status: 30 October 2013

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

General overview

St Clair Park residential centre provides residential care for up to 35 residents at three service levels including residential disability (intellectual, physical, sensory), mental health, and rest home level care. On the day of the audit, there were 29 residents.

St Clair Park is managed by a registered nurse (RN). He holds a current practising certificate and has extensive experience in mental health. The manager is supported by two RNs, one of whom is nominated as clinical leader for four aged care residents and both are employed by the service 30 hours per week. Residents interviewed all spoke very positively about the care and support provided.

Since the previous certification audit, seventeen of the 23 shortfalls have been addressed by the service. The following improvements continue to be required in regards to: completion of all corrective actions; conducting pain assessments; aspects of medication management; secure storage of chemicals; and availability of lifting equipment.

This current audit identified further improvements required in regards to: building warrant of fitness; family notification of health changes; on-going education for all staff including manager and registered nurses; job description for clinical leader; orientation documentation; business goals; implementation of quality and risk management programme; and assessment and care planning documentation.

Audit Summary as at 30 October 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

Indicator	Description	Definition
	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 30 October 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 medium or high risk and/or unattained and of low risk.
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Organisational Management as at 30 October 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.		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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Continuum of Service Delivery as at 30 October 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 30 October 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 medium or high risk and/or unattained and of low risk.
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Restraint Minimisation and Safe Practice as at 30 October 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 30 October 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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HealthCERT Service Provider Audit Report (version 5.9)

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 a health and disability service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

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

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

Audit Report

Legal entity name:	St Clair Park Residential Centre Ltd
Certificate name:	St Clair Park Residential Centre
Designated Auditing Agency:	HDANZ
Types of audit:	Surveillance
Premises audited:	St Clair Park, 287 Middleton Rd, Dunedin
Services audited:	Rest Home, Residential – physical, psychiatric, intellectual disability
Dates of audit:	Start date: 30 October 2013 End date: 30 October 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:	29
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Audit Team

		Hours on site	9	Hours off site	6
Other Auditors	XXXXX	Total hours on site	9	Total hours off site	5
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	18	Total audit hours off site	14	Total audit hours	32
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Number of residents/patients interviewed	10	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents'/patients' records reviewed	4	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	28	Number of relatives interviewed	
Number of residents'/patients' records reviewed using tracer methodology	3			Number of GPs interviewed (Residential Disability providers only)	

Declaration

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

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Wednesday, 15 January 2014

Executive Summary of Audit

General Overview

St Clair Park residential centre provides residential care for up to 35 residents at three service levels including residential disability (intellectual, physical, sensory), mental health, and rest home level care. On the day of the audit, there were 29 residents.

St Clair Park is managed by a registered nurse (RN). He holds a current practising certificate and has extensive experience in mental health. The manager is supported by two RNs, one of whom is nominated as clinical leader for four aged care resident and both are employed by the service 30 hours per week. Residents interviewed all spoke very positively about the care and support provided. Seventeen of the 23 shortfalls have been addressed by the service since previous.

The following improvements continue to be required by the service in regards to: completion of all corrective actions; conducting pain assessments; aspects of medication management; secure storage of chemicals; and availability of lifting equipment.

This audit identified the further improvements required by the service in regards to: building warrant of fitness; family notification of health changes; on-going education for all staff including manager and registered nurses; job description for clinical leader; orientation documentation; business goals; implementation of quality and risk management programme; and assessment and care planning documentation.

Outcome 1.1: Consumer Rights

An open disclosure policy is in place. No family were available during this spot surveillance audit. There is a lack of evidence to confirm family are kept informed.

The complaints policy outlines the process for managing complaints. Complaints forms are available at the entrance to the facility. Four residents who were interviewed report the nurse manager are available to them if they have any concerns. They also expressed confidence in raising issues during residents' meetings.

Outcome 1.2: Organisational Management

St Clair Park is owned by an overseas investor and is managed by a nurse manager who has previous experience in mental health. He is assisted by a clinical leader/registered nurse who graduated from nursing school two years ago.

There is evidence of two yearly policy reviews. This is an improvement from the previous audit.

The nurse manager is aware of statutory reporting requirements. A range of data is collected each month including (but not limited to); falls, challenging behaviour, and infections.

Professional qualifications are verified for all qualified staff. Police checks are conducted for new staff. Education and training programmes

meet contractual obligations. Restraint minimisation and de-escalation training is in place. This is an improvement from the previous audit. The staffing rosters confirm there is adequate staff available to safely meet the needs of the residents. Required improvements include the following: The nurse manager and registered nurse (clinical leader) lack adequate experience in aged care to manage this facility; the newly appointed (clinical leader) does not hold a job description for her role as clinical leader; the quality and risk management programme is fragmented and does not incorporate a culture of continuous quality improvement; quality meeting minutes are not being documented; data that is collected is not analysed, evaluated and discussed with staff; there is a lack of evidence to demonstrate recommendations resulting from internal audits are implemented and signed off; a risk management plan is not in place, the hazard register has not been reviewed since 2006; a system to identify new hazards is missing; incidents and accidents are not consistently documented on the appropriate form; there is a lack of evidence of the timely, appropriate and thorough investigation and sign off of adverse events by the registered nurses; completed orientation checklists were missing in three out of six staff files, and there is a lack of evidence to demonstrate adequate time is devoted to new employee orientation.

Outcome 1.3: Continuum of Service Delivery

Residents at St Clair Park Residential Centre are assessed prior to entry by the needs assessment team, and an initial assessment is completed on admission. Care plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Caregivers complete progress notes at the end of each shift. Improvements are required around care plan documentation, the use of short term care plans and timeframes for review.

There is a recreation/activities programme which offers activities that are varied, age appropriate and include local community and entertainment events. Recreation/activity plans include goals and interventions to achieve the goals. Recreation/activity plans are reviewed three monthly. The medication management system is appropriate and safely implemented. Resident medications are reviewed at least three monthly. Staff responsible for medication administration are trained and have been assessed as competent. Improvements are required around medication documentation.

Outcome 1.4: Safe and Appropriate Environment

The building warrant of fitness expired 6/7/13. The building currently doesn't have a warrant of fitness due to incomplete documentation supplied for compliance. The service has employed an IQP to ensure that inspections continue. The building systems are deemed functional. There are no lifting devices other than lifting belts used by staff. The facility has a 'no lift' policy although staff continue to assist residents to a standing position if the resident has not hurt himself. This remains an improvement from the previous audit.

Outcome 2: Restraint Minimisation and Safe Practice

The registered nurse (clinical leader) reports there have been no instances of restraint or enabler use since July 2012. Policies and procedures

are in place in the event restraint is used, covering the procedures of approving appropriate restraints, assessing a resident's suitability to restraint, monitoring restraint, reviewing the use of restraint, evaluating restraint, and maintaining a restraint register. This is an improvement from the previously identified shortfalls under the restraint minimisation standard.

Outcome 3: Infection Prevention and Control

Infection control policies and procedures are documented and reflect best practice. The registered nurse (clinical leader) is the Infection control co-ordinator and she has attended external education with 'Bug Control' in 2012 and infection control in service have been provided to staff 21/9/2013. This is an improvement from previous audit. Monthly infection control surveillance occurs and analysis of monthly data occurs. Graphs are available with comparisons of 2012/2013 occurring. Regular reporting of infection control issues to the quality meeting occurs. Compliance with infection control practices is evaluated by the IC coordinator through internal audits, the results of surveillance data and observation.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	10	0	3	10	0	0
Criteria	0	37	0	9	12	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	83

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		with consumers and provide an environment conducive to effective communication.				
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Moderate	A relative satisfaction survey was recently conducted in September 2013. Seven of 13 respondents reported on the survey they are not kept informed. Thirty accident and incident forms were reviewed August – October 2013. There is space on the form to document when families are contacted. There was no evidence of families being contacted on any of the accident incident forms, even in instances where families had indicated that they wish to be contacted. There was also no evidence in the residents' progress notes of families being informed.	Ensure there is evidence to support open disclosure following a change in a residents' condition, or following an adverse event.	30
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned,	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		coordinated, and appropriate to the needs of consumers.				
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	The business plan 2013 documents goals for the service but lacks a purpose, values, scope and direction. Business objectives are under the categories of general (physical environment), lifestyle planning, risk minimisation, personal finances, home agreements, choice and participation, household routines, menu planning, family/whanau involvement, advocacy, food and name badges for staff. There is a lack of evidence to indicate business goals are reflected on and progressed throughout the year (monthly management meeting minutes sighted).	Ensure the purpose, scope, and direction of the service are defined. Ensure a process is in place for the regular review of the business goals.	180
HDS(C)S.2008	Criterion 1.2.1.3	The organisation is managed by a suitably qualified and/or	PA Moderate	The nurse manager reports he has no prior experience managing	Ensure the manager becomes familiar with the NZS 8134 HDSS	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		experienced person with authority, accountability, and responsibility for the provision of services.		an aged care facility but has managed other residential facilities and was operations manager for a non-governmental organisation (NGO) in the Southern Region from 1996 to 2001. He is unfamiliar with the NZS 8134 HDSS Standard. He has undertaken only six hours of professional development relating to the management of an aged care facility since his appointment. The clinical leader has only two years of experience. She receives no professional supervision or mentoring by an experienced clinical nurse. She does not have a current job description.	Standard and attends a minimum of eight hours of professional development per year relating to the management of an aged care facility. Ensure the clinical leader holds a current job description and receives regular professional supervision.	
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		quality improvement principles.				
HDS(C)S.2008	Criterion 1.2.3.1	The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Low	The quality and risk management system is fragmented and lacks a continuous quality improvement culture. An internal auditing programme is in place with evidence of monthly audits although an internal auditing schedule was not available for sighting. There is a lack of evidence to reflect links between the 2013 business objectives and the quality and risk management system (refer 1.2.3.1). Management meetings are held monthly. Meeting minutes reflect reference to the manager's report with no documented evidence of discussions, follow-up actions or person(s) responsible for actions. There are monthly quality assurance meetings	The quality and risk management programme needs to reflect the principles of continuous quality improvement. The nurse leader requires further education and training relating to quality systems. Meeting minutes are required for the quality meetings. Meeting minutes need to document discussions, follow-up actions and persons responsible.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				but meeting minutes are not being documented.		
HDS(C)S.2008	Criterion 1.2.3.5	Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	<p>There is no evidence of the regular monitoring of the hazard register (refer 1.2.3.9). A complaints register (sighted) is in place. Individual issues identified are investigated on a case by case basis. Twenty-five complaints lodged by staff in 2013 have not been trended or analysed. Incident analysis is reported through the management meetings with information also being reported through quality meetings although quality meeting minutes were not available for sighting (refer 1.2.3.1). There is no evidence to reflect the trending or analysis of accidents and incidents. The internal audit</p>	Key components of service delivery need to be explicitly linked to the quality management system.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				programme lacks a planned schedule.		
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is no evidence to reflect the systematic trending or analysis of data.	Quality improvement data that is collected must be analysed, evaluated and results communicated to staff and where appropriate, consumers.	180
HDS(C)S.2008	Criterion 1.2.3.7	A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Business goals are not linked to the quality and risk management plan. Staff are not regularly informed of internal audit results. A process to measure achievements against the quality and risk management plan is not in place.	Ensure a process to measure achievement against the quality and risk management plan is in place.	180
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	There is no evidence of corrective actions being discussed in the management meetings, quality meetings or staff meetings. There is a lack of evidence to reflect corrective actions resulting from internal audits are implemented and	Ensure there is documented evidence of corrective actions implemented and signed off when completed.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>closed. This remains an improvement from the previous audit. Monthly resident meetings sighted for 2013 document actions required, as evidenced in the residents' meeting minutes and discussion with the activities coordinator. This is an improvement from the previous audit. There is also a lack of documented evidence to reflect corrective actions taken following concerns expressed by family and complaints lodged by staff. (link 1.3.13)</p>		
HDS(C)S.2008	Criterion 1.2.3.9	<p>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:</p> <p>(a) Identified risks are</p>	PA Moderate	<p>A risk management plan was unavailable for sighting. The nurse manager is unaware of a risk management plan for the facility. The nurse manager was unaware of a hazard register for the facility. When it was</p>	<p>A risk management plan for the service is required. The hazard register requires review. A system for the identification of new hazards is required.</p>	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		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.		located (by the auditor), it is noted the hazard register was last updated in 2006. There is no system in place for the identification of new hazards.		
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Three incidents documented in residents' progress notes for Sept and October do not include completed accident and incident forms. Two of three caregivers interviewed remarked they injured their backs when lifting a resident off the floor. There is no evidence of completed accident forms for these two events.	Ensure adverse event forms are completed. Completed forms are required to undergo an appropriate and thorough investigation and sign-off by an RN.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				Three accidents documented for October 2013 fail to reflect an investigation or sign-off by either the nurse manager or the clinical leader. One incident in particular (dated 2 October 2013) relates to a medication error whereby residents were give two lots of 5pm meds and no 8 o'clock meds were available. The corrective action documented by the nurse manager on the incident form was 'ordered more medication' (refer 1.3.12).		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of	PA Low	St Clair Park has an orientation programme that provides new staff with relevant information for safe	Ensure completed orientation checklists are returned and filed. Ensure adequate time is spent orientating new	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		the service provided.		<p>work practice. The orientation programme includes sign-off of a number of areas including: hygiene/grooming, food safety, infection control. In the six files reviewed, completed and signed orientation checklists were sighted in three of the six staff files. Missing were orientation checklists for one RN and two caregiver staff. Three caregiver interviews and the interview with the clinical leader report the time spent orientating new staff is inadequate with the period of induction not long enough. Caregiver staff report they were 'thrown' into work duties after their orientation.</p>	staff to the service.	
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 Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.3.6	The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.	PA Low	One file (mental health) includes a mental health personal plan and goals written 14/7/12, including a risk management plan with early signs for relapse identified, and plan if behaviour changes. Same goals have been reviewed but have no date indicating when this occurred.	Ensure goals are dated to indicate when reviews occurred	60
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	a) Pain assessment are completed for residents receiving controlled drugs, however resident with chronic pain and receiving regular analgesic (other than controlled medication) has no pain assessment or monitoring occurring to ascertain the effectiveness of his pain relief. b) Assessment tools are	a) Complete pain assessments for all residents receiving regular analgesia and monitor the effectiveness of pain medication b) Review assessment tools as part of the care plan review process 6 monthly prn and update care plan following changes. c) Ensure up to date information is provided prior to admission. d) Ensure	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>used for continence, falls risk, pressure area risk; however these have not been reviewed since August 2012. c) One of the four files reviewed contained a Needs assessment completed one year prior (1/8/11) to admission date (15/8/12). d) An intellectual disability lifestyle plan was completed in June 2012. Goals and updates have been documented but include no dates to identify when these occurred. e) Rest home resident with physical disability is to be reassessed with the possibility of him being discharged into the community. Registered nurse (clinical leader) confirmed that resident was being assessed for a move to the community; however there was no documentation in</p>	<p>lifestyle plan updates are dated to identify when updates occur. e) Document all changes to care needs.</p>	

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				regards to this change in his care requirements.		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Interventions are not occurring in a timely fashion to ensure that residents receive a desirable outcome for their changes in health status.	Ensure interventions occur in a timely fashion.	30
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 Low			
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 Low	One resident file (intellectual disability) contained no activity checklist or activity plan.	Ensure all residents have an activity plan developed.	60
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		comprehensive and timely manner.				
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	Short term care plans have not been utilised when acute or short term changes in health occur. eg a) resident with rectal bleeding, b) resident with shortness of breath c) resident undergoing treatment for cancer and a d) resident with UTI following surgery	Document short term care plan when resident health status changes.	60
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 Moderate			
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 Moderate	One chart identified medication instruction sheet had not been signed by general practitioner.	All medication instruction sheets must be signed by residents' general practitioners or specialist	30
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a	PA Moderate	a) Six out of twelve charts reviewed	a) Document reasons why medication has not	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.		identified gaps in signing sheets (eleven times), with no reason documented why medication not given. b) No documentation is completed following the administration of PRN medication to assess effectiveness of medication given.	been administered and identify on medication administration sheet. b) Document effectiveness or otherwise following administration of PRN medication.	
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.1.1	Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Moderate	On day of audit, the cleaning trolley was left unattended in Cargill area and one chemical dispenser was not labelled with manufacturer label.	Ensure that all chemicals are stored safely and securely. Ensure all chemicals are labelled with the manufacturer label.	7
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and	PA Moderate	The services Bwof	Ensure that	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		equipment comply with legislation.		expired 6/7/2013.	inspections, maintenance and reporting for the systems on the compliance schedule for the next 12 months occur, to allow a properly completed Bwof to be produced next year.	
HDS(C)S.2008	Criterion 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Moderate	There are no lifting devices available other than lifting belts. The nurse manager reports the facility has a 'no lift' policy. Three caregiver interviews state that they understand there is a no-lift policy but they continue to assist residents to their feet if a resident has not sustained an injury following a fall, instead of calling an ambulance. Two staff report they injured their backs last year lifting residents who had fallen. Contacting ambulance services when no injury has been sustained is not an appropriate use of	Ensure systems are in place to minimise the risk of harm to staff.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				external resources. Nor are residents who are uninjured always able to stand unaided following a fall. A no lift policy in a facility where residents fall but do not harm themselves has not proven effective. This remains an improvement from the previous audit.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There is an open disclosure policy.

No family were available during this spot surveillance audit. The nurse manager reports the residents' relative have indicated if they would like to be contacted in the event of a change in the resident's condition or an adverse event. This information is held at the nursing stations (sighted). Resident meetings occur monthly, led by the activities coordinator.

Documentation does not support families being contacted if a resident's condition changes or following an adverse event affecting the resident. There is a required improvement.

D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

D16.4b The admission information and agreement booklet contains information about open disclosure. The code of resident's rights and responsibilities, open disclosure policy and informed consent policies state that the residents have the right to full and frank information.

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: PA Moderate

Evidence:

There is an open disclosure policy.

No family were available during this spot surveillance audit. The nurse manager reports the residents' relative have indicated if they would like to be contacted in the event of a change in the resident's condition or an adverse event. This information is held at each nursing station (sighted). Resident meetings occur monthly, led by the activities coordinator.

A relative satisfaction survey was recently conducted in September 2013. Seven of 13 respondents reported on the survey they are not kept informed. Thirty

accident and incident forms were reviewed August – October 2013. There is space on the form to document when families are contacted. There was no evidence of families being contacted on any of the accident incident forms, even in instances where families had indicated that they wish to be contacted. There was also no evidence in the residents' progress notes of families being informed.

At the time of audit, there were no residents who required an interpreter. If required, this can be accessed through the DHB.

D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

D16.4b The admission information and agreement booklet contains information about open disclosure. The code of resident's rights and responsibilities, open disclosure policy and informed consent policies state that the residents have the right to full and frank information.

Finding:

A relative satisfaction survey was recently conducted in September 2013. Seven of 13 respondents reported on the survey they are not kept informed. Thirty accident and incident forms were reviewed August – October 2013. There is space on the form to document when families are contacted. There was no evidence of families being contacted on any of the accident incident forms, even in instances where families had indicated that they wish to be contacted. There was also no evidence in the residents' progress notes of families being informed.

Corrective Action:

Ensure there is evidence to support open disclosure following a change in a residents' condition, or following an adverse event.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence: St Clair Park's complaints policy outlines the process for managing complaints and complies with Right 10 of the Code. Forms are available at the entrance to the facility. Staff (three caregivers, one clinical leader) demonstrated an understanding of the complaints process. Ten residents interviewed (two intellectual disability, three physical disability, three rest home and two mental health) reported that they feel comfortable discussing any concerns they may have with the nurse manager or in a residents' meeting. There is a complaints register in place. In 2013, 25 complaints had been lodged in the complaints register by staff complaining about other staff. There is no evidence of these complaints being actioned as per the quality management system (link 1.2.3.8). The nurse manager reports no complaints from residents or family have been lodged in 2013. Complaints are recorded either on a complaint/compliment reporting form or an incident/accident/suggestion/near miss/ complaint/compliment form. The nurse manager then transfers complaints to a complaints log sheet (register) for his follow-up. There were two relative survey results out of 13 whereby concerns were made by relatives. There is no documented evidence of corrective actions undertaken as a result of these documented concerns (link 1.2.3.8).

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.

Attainment and Risk: PA Moderate
Evidence: <p>St Clair Park provides care for up to 35 residents who require either rest home level care or residential services. On the day of audit there were 29 residential residents – six intellectual, five physical, 14 mental health; and four residents under an aged care contract. The facility is owned by an overseas investor. A director is appointed who meets weekly with the nurse manager. The nurse manager reports there are set questions that are reviewed each week (no meeting minutes were available for sighting).</p> <p>The 2013 business plan documents goals for the service but lacks a purpose, values, scope and direction. Business objectives are under the categories of general (physical environment), lifestyle planning, risk minimisation, personal finances, home agreements, choice and participation, household routines, menu planning, family/whanau involvement, advocacy, food and name badges for staff. There is a lack of evidence to indicate business goals are reflected on and progressed throughout the year (monthly management meeting minutes sighted).</p>

St Clair Park is managed by a registered nurse (RN). He holds a current practising certificate and has extensive experience in mental health. He has been employed by the service for 18 months and works on a full-time basis. Prior to his employment at St Clair Park, he was working in America for five years implementing a case management system.

The nurse manager reports he has no prior experience managing an aged care facility but has managed other residential facilities and was operations manager for a non-governmental organisation (NGO) in the Southern Region from 1996 to 2001. The nurse manager is unfamiliar with the NZS 8134 Health and Disability Sector Standard. He reports he would like to attend further study on implementing quality systems. Since his return to New Zealand, he has attended six hours of professional development activities relating the management of an aged care facility ('Employment Law (four hours), 'Outbreak Management' (two hours).

The manager is supported by a clinical leader who is employed by the service 30 hours per week. The clinical leader qualified as an RN two years ago and has been employed by the service for 18 months. The clinical leader reports the Southern District Health Board prompted her recent appointment as a clinical leader due to the lack of clinical experience of the nurse manager. The clinical leader is mentoring a new graduate registered nurse who is also employed by the service for 30 hours per week. The clinical leader reports she receives no external supervision or mentoring by an experience clinical RN. She reports she does not have a current job description.

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: PA Low

Evidence:

St Clair Park provides care for up to 35 residents who require either rest home level care or residential services. On the day of audit there were twenty-nine residential residents – six intellectual, five physical, fourteen mental health; and four residents under an aged care contract. The facility is owned by an overseas investor. A director is appointed who meets weekly with the nurse manager. The nurse manager reports there are set questions that are reviewed each week (no meeting minutes were available for sighting).

The 2013 business plan documents goals for the service but lacks a purpose, values, scope and direction. Business objectives are under the categories of general (physical environment), lifestyle planning, risk minimisation, personal finances, home agreements, choice and participation, household routines, menu planning, family/whanau involvement, advocacy, food and name badges for staff. There is a lack of evidence to indicate business goals are reflected on and progressed throughout the year (monthly management meeting minutes sighted).

Finding:

The business plan 2013 documents goals for the service but lacks a purpose, values, scope and direction. Business objectives are under the categories of general (physical environment), lifestyle planning, risk minimisation, personal finances, home agreements, choice and participation, household routines, menu planning, family/whanau involvement, advocacy, food and name badges for staff. There is a lack of evidence to indicate business goals are reflected on and progressed throughout the year (monthly management meeting minutes sighted).

Corrective Action:

Ensure the purpose, scope, and direction of the service are defined. Ensure a process is in place for the regular review of the business goals.

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

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

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

Attainment and Risk: PA Moderate

Evidence:

St Clair Park is managed by a registered nurse (RN). He holds a current practising certificate and has extensive experience in mental health. He has been employed by the service for 18 months and works on a full-time basis. Prior to his employment at St Clair Park, he was working in America for five years implementing a case management system.

He reports he has no prior experience managing an aged care facility but has managed other residential facilities and was operations manager for a non-governmental organisation (NGO) in the Southern Region from 1996 to 2001. The nurse manager is unfamiliar with the NZS 8134 Health and Disability Sector Standard. He reports he would like to attend further study on implementing quality systems. Since his return to New Zealand, he has attended six hours of professional development activities relating to the management of an aged care facility ('Employment Law (four hours), 'Outbreak Management' (two hours).

The manager is supported by a clinical leader who is employed by the service 30 hours per week. The clinical leader qualified as an RN two years ago and has been employed by the service for eighteen months. The clinical leader reports the Southern District Health Board prompted her recent appointment as a clinical leader due to the lack of clinical experience of the nurse manager. The clinical leader is mentoring a new graduate registered nurse who is also employed by the service for 30 hours per week. The clinical leader reports she receives no external supervision or mentoring by an experience clinical RN. She reports she does not have a current job description.

Finding:

The nurse manager reports he has no prior experience managing an aged care facility but has managed other residential facilities and was operations manager for a non-governmental organisation (NGO) in the Southern Region from 1996 to 2001. He is unfamiliar with the NZS 8134 HDSS Standard. He has undertaken only six hours of professional development relating to the management of an aged care facility since his appointment.

The clinical leader has only two years of experience. She receives no professional supervision or mentoring by an experienced clinical nurse. She does not have a current job description.

Corrective Action:

Ensure the manager becomes familiar with the NZS 8134 HDSS Standard and attends a minimum of eight hours of professional development per year relating to the management of an aged care facility. Ensure the clinical leader holds a current job description and receives regular professional supervision.

Timeframe (days): 90 (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.

Attainment and Risk: PA Moderate

Evidence:

St Clair Park is an adult care facility catering for adults with an intellectual or physical disability; mental health issue; of adults requiring rest home level aged care.

The quality and risk management system is fragmented, lacking a continuous quality improvement approach to the management of quality and risk. An internal auditing programme is in place with evidence of monthly audits although an internal auditing schedule was not available for sighting. There is a lack of evidence to reflect links between the 2013 business objectives and the quality and risk management system.

Management meetings are held monthly. Meeting minutes reflect reference to the manager's report with no documented evidence of discussions, follow-up actions or person(s) responsible for actions. There are monthly quality assurance meetings but the clinical leader and nurse manager report meeting minutes are not being documented.

St Clair Park has policy manuals for nursing, staff, restraint and infection control. Policies have been reviewed and updated where required, evidenced on the footer section of the policies. This is an improvement from the previous audit. The nurse manager and clinical leader undertake policy reviews. The nurse manager reports updates are taken to staff. There are policies and tools for the following: a continence assessment policy; pain management policy; hygiene needs of a resident policy; skin care policy; wounds management procedure; policy in event of death and a challenging behaviour policy.

A document control system is in place. Evidence of amended policies are located as a face sheet in the front of each policy manual. A folder, held in the staff room, contains new and updated policies. Staff are required to read the new policies and sign after they have been read. The nurse manager reports new policies are discussed in staff meetings. This was further evidenced in interviews with the clinical leader and three caregivers. The manager is responsible for the removal of obsolete documents and forms. Documents are archived securely.

The components of service delivery that are regularly monitored include the following:

- a) There is a newly appointed health and safety officer who is responsible for temperature monitoring. There is no evidence of the regular monitoring of the hazard register (refer 1.2.3.9).
- b) A complaints register (sighted) is in place. Individual issues identified are investigated on a case by case basis. Twenty-five complaints

lodged by staff in 2013 have not been trended or analysed (link 1.1.13).

c) Incident analysis is reported through the management meetings with information also being reported through quality meetings although quality meeting minutes were not available for sighting (refer 1.2.3.1). There is no evidence to reflect the trending or analysis of accidents and incidents.

d) Infection control surveillance monitoring is in place (refer 3.5).

e) No restraints are in place.

A number of indicators are reported using the reporting form summary for staff meetings including falls, skin tear, and bruising, challenging behaviour. Numbers are identified in the meeting minutes. There is no evidence to reflect trending or analysis of data. Instead, adverse events are dealt with on a case by case basis.

There are business goals for 2013 that identify goals for the year. There is a lack of evidence of goals being monitored with progress being reported (refer 1.2.3.1).

Management meetings occur monthly. Standing items include: complaints, accidents/incidents; and education. Monthly staff meetings include the regular agenda items of accident/incidents, internal audit results (Sept 2013 and Oct 2013 only); complaints, infection control. Meeting minutes generally refer to the manager's report and/or the nursing report. There is no evidence of actions plans or persons responsible since 12 June 2012. There is also a lack of documented evidence to reflect corrective actions taken following concerns expressed by family and complaints lodged by staff. (link 1.3.13)

There is an internal audit programme being implemented although an internal audit schedule was not available for sighting. Internal audits were reviewed from January through June 2013. The range of audits undertaken includes: recreation audit (Mar 2013); hygiene audit (Feb 2013); laundry audit (Feb 2013); challenging behaviours audit (Jun 2013). The nurse manager is responsible for completing these audits. There is evidence of documented corrective actions (recommendations), developed by the nurse manager, following the scoring of audits where opportunities for improvements are noted. There is no evidence of corrective actions being discussed in the management, quality or staff meetings (refer 1.2.3.1). Monthly resident meetings sighted for 2013 document actions required although these are very few, as evidenced in the residents' meeting minutes and discussion with the activities coordinator. This is an improvement from the previous audit.

A risk management plan was unavailable for sighting. The nurse manager does not think a risk management plan for the service is in place. St Clair Park has a health and safety manual to support staff practice. The health and safety manual includes information on the management of hazards and ways to minimise and eliminate hazards. There is a recently appointed health and safety representative recently attended health and safety training (the health and safety representative was not available on the day of the audit). Staff accidents and incidents are recorded on the incident/accident forms. Two caregiver staff report injuring their back when lifting patients. Evidence of completed staff accident forms for these occurrences were not completed. Monthly building compliance audits are in place although one month is missing resulting in a building warrant of fitness not being issued by the Dunedin City Council (refer 1.2.4.2).

The nurse manager was unaware of a hazard register (refer 1.2.3.1). When it was located (by the auditor), it is noted the hazard register was last updated in 2006. There is no system in place for the identification of new hazards.

D19.3 Health and safety policies and procedures are in place
D19.2g Falls prevention - areas are well lit, call bells are accessible.

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: PA Low

Evidence:

St Clair Park is an adult care facility catering for adults with an intellectual or physical disability; mental health issue; of adults requiring rest home level aged care.

The quality and risk management system is fragmented and lacks a continuous quality improvement culture. An internal auditing programme is in place with evidence of monthly audits although an internal auditing schedule was not available for sighting. There is a lack of evidence to reflect links between the 2013 business objectives and the quality and risk management system.

Management meetings are held monthly. Meeting minutes reflect reference to the manager's report with no documented evidence of discussions, follow-up actions or person(s) responsible for actions. There are monthly quality assurance meetings but meeting minutes are not being documented.

Finding:

The quality and risk management system is fragmented and lacks a continuous quality improvement culture. An internal auditing programme is in place with evidence of monthly audits although an internal auditing schedule was not available for sighting. There is a lack of evidence to reflect links between the 2013 business objectives and the quality and risk management system (refer 1.2.3.1).

Management meetings are held monthly. Meeting minutes reflect reference to the manager's report with no documented evidence of discussions, follow-up actions or person(s) responsible for actions. There are monthly quality assurance meetings but meeting minutes are not being documented.

Corrective Action:

The quality and risk management programme needs to reflect the principles of continuous quality improvement. The nurse leader requires further education and training relating to quality systems. Meeting minutes are required for the quality meetings. Meeting minutes need to document discussions, follow-up actions and persons responsible.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: PA Low

Evidence:

The components of service delivery that are regularly monitored include the following:

- a) There is a newly appointed health and safety officer who is responsible for temperature monitoring. There is no evidence of the regular monitoring of the hazard register (refer 1.2.3.9).
- b) A complaints register (sighted) is in place. Individual issues identified are investigated on a case by case basis. Twenty-five complaints lodged by staff in 2013 have not been trended or analysed (refer 1.2.3.6).
- c) Incident analysis is reported through the management meetings with information also being reported through quality meetings although quality meeting minutes were not available for sighting (refer 1.2.3.1). There is no evidence to reflect the trending or analysis of accidents and incidents (refer 1.2.3.6). There is an internal audit programme being implemented although an internal audit schedule was not available for sighting. Internal audits were reviewed from January through June 2013. The range of audits undertaken includes: recreation audit (March 2013); hygiene audit (Feb 2013); laundry audit (Feb 2013); challenging behaviours audit (June 2013). The nurse manager is responsible for completing these audits.

Finding:

There is no evidence of the regular monitoring of the hazard register (refer 1.2.3.9).

A complaints register (sighted) is in place. Individual issues identified are investigated on a case by case basis. Twenty-five complaints lodged by staff in 2013 have not been trended or analysed.

Incident analysis is reported through the management meetings with information also being reported through quality meetings although quality meeting minutes were not available for sighting (refer 1.2.3.1). There is no evidence to reflect the trending or analysis of accidents and incidents.

The internal audit programme lacks a planned schedule.

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low
Evidence: A number of indicators are reported using the reporting form summary for staff meetings including falls, skin tears, bruising, and episodes of challenging behaviour. Numbers of occurrences are identified in the meeting minutes. There is no evidence to reflect the trending or analysis of data. Instead, data is managed on a case by case basis.
Finding: There is no evidence to reflect the systematic trending or analysis of data.
Corrective Action: Quality improvement data that is collected must be analysed, evaluated and results communicated to staff and where appropriate, consumers.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Low
Evidence: There are business goals for 2013 (refer 1.2.3.1) that identify goals for the year. There is a lack of evidence of goals being monitored with progress being reported (refer 1.2.3.1). Management meetings occur monthly. Standing items include: complaints, accidents/incidents; and education. Monthly staff meetings include the regular agenda items of accident/incidents, internal audit results (Sept 2013 and Oct 2013 only); complaints, infection control. Meeting minutes generally refer to the manager's report and/or the nursing report. There is no evidence of actions plans or persons responsible since 12 June 2012.
Finding: Business goals are not linked to the quality and risk management plan. Staff are not regularly informed of internal audit results. A process to measure achievements against the quality and risk management plan is not in place.

Corrective Action:

Ensure a process to measure achievement against the quality and risk management plan is in place.

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

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

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

Attainment and Risk: PA Low

Evidence:

There is evidence of documented corrective actions (recommendations), developed by the nurse manager, following the scoring of internal audits where opportunities for improvements are noted. There is no evidence of corrective actions being discussed in the management meetings, quality meetings or staff meetings. There is a lack of evidence to reflect corrective actions resulting from internal audits are implemented and closed. This remains an improvement from the previous audit.

Monthly resident meetings sighted for 2013 document actions required, as evidenced in the residents' meeting minutes and discussion with the activities coordinator. This is an improvement from the previous audit.

Finding:

There is no evidence of corrective actions being discussed in the management meetings, quality meetings or staff meetings. There is a lack of evidence to reflect corrective actions resulting from internal audits are implemented and closed. This remains an improvement from the previous audit.

Monthly resident meetings sighted for 2013 document actions required, as evidenced in the residents' meeting minutes and discussion with the activities coordinator. This is an improvement from the previous audit. There is also a lack of documented evidence to reflect corrective actions taken following concerns expressed by family and complaints lodged by staff. (link 1.3.13)

Corrective Action:

Ensure there is documented evidence of corrective actions implemented and signed off when completed.

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: PA Moderate
Evidence: A risk management plan was unavailable for sighting. The nurse manager is unaware of a risk management plan for the facility. St Clair Park has a health and safety manual to support safe practice. The health and safety manual includes information on the management of hazards and ways to minimise and eliminate hazards. There is a recently appointed health and safety representative who the nurse manager reports recently attended health and safety training (the health and safety representative was not available on the day of the audit). The nurse manager was unaware of a hazard register for the facility. When it was located (by the auditor), it is noted the hazard register was last updated in 2006. There is no system in place for the identification of new hazards. D19.3 Health and safety policies and procedures are in place D19.2g Falls prevention - areas are well lit, call bells are accessible.
Finding: A risk management plan was unavailable for sighting. The nurse manager is unaware of a risk management plan for the facility. The nurse manager was unaware of a hazard register for the facility. When it was located (by the auditor), it is noted the hazard register was last updated in 2006. There is no system in place for the identification of new hazards.
Corrective Action: A risk management plan for the service is required. The hazard register requires review. A system for the identification of new hazards is required.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate

Evidence:

The provider is aware of required reporting and has policy to support practice - incorporated in the incident reporting policy and procedures. There is evidence of the Ministry being informed of a serious medication incident (refer 1.3.12) and of the Southern District Health Board (SDHB) being contacted following an incident of assault. (refer 1.3.3) Appropriate follow-up actions have been taken in each instance.

D19.3d the service is aware that they must inform the DHB of any serious accidents or incidents

St Clair Park collects a range of data monthly that is provided in numbers in the manager's report, and staff meetings. Examples include: falls, challenging behaviour and infection control surveillance. Corrective actions are dealt with on a case-by-case basis with no evidence of the analyses or trending of adverse event data.

Three incidents documented in residents' progress notes for September and October do not include completed accident and incident forms. Two of three caregivers interviewed remarked they injured their backs when lifting a resident off the floor. There is no evidence of completed accident forms for these two events.

Three accidents documented for October 2013 fail to reflect an investigation or sign-off by either the nurse manager or the clinical leader. One incident in particular relates to a medication error whereby two residents failed to receive their medications at the appropriate time, and their medications had run out. The corrective action documented by the nurse manager on the incident form was 'ordered more medication' (refer 1.3.12).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

St Clair Park collects a range of data monthly that is provided in numbers in the manager's report, and staff meetings. Examples include: falls, challenging behaviour and infection control surveillance. Corrective actions are dealt with on a case-by-case basis with no evidence of the analyses or trending of adverse event data.

Three incidents documented in residents' progress notes for Sept and October do not include completed accident and incident forms. Two of three caregivers interviewed remarked they injured their backs when lifting a resident off the floor. There is no evidence of completed accident forms for these two events.

Three accidents documented for October 2013 fail to reflect an investigation or sign-off by either the nurse manager or the clinical leader. One incident in particular relates to a medication error whereby two residents failed to receive their medications at the appropriate time, and their medications had run out. The corrective action documented by the nurse manager on the incident form was 'ordered more medication' (refer 1.3.12).

Finding:

Three incidents documented in residents' progress notes for Sept and October do not include completed accident and incident forms. Two of three caregivers interviewed remarked they injured their backs when lifting a resident off the floor. There is no evidence of completed accident forms for these two events.

Three accidents documented for October 2013 fail to reflect an investigation or sign-off by either the nurse manager or the clinical leader. One incident in particular (dated 2 October 2013) relates to a medication error whereby residents were given two lots of 5pm medications and no 8 o'clock medications were available. The corrective action documented by the nurse manager on the incident form was 'ordered more medication' (refer 1.3.12).

Corrective Action:

Ensure adverse event forms are completed. Completed forms are required to undergo an appropriate and thorough investigation and sign-off by an RN.

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

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

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

Attainment and Risk: PA Low

Evidence:

Professional qualifications are verified at the time of employment and an on-going record is kept for the RNs and GP. A current practising certificate was sighted for three of three RNs (staff RN, clinical leader, and nurse manager).

Six staff files were randomly selected for audit. The original sample size was four with the sample increased to identify trends. Police checks are conducted for new staff. Performance appraisals are up-to-date. There are human resources policies supporting recruitment, selection, orientation and staff training and development.

St Clair Park has an orientation programme that provides new staff with relevant information for safe work practice. The orientation programme includes sign-off of a number of areas including: hygiene/grooming, food safety, infection control. In the six files reviewed, completed and signed orientation checklists were sighted in three of the six staff files. Missing were orientation checklists for one RN and two caregiver staff. Three caregiver interviews and the interview with the clinical leader report the time spent orientating new staff is inadequate with the period of induction only one day. Caregiver staff report they were 'thrown' into work duties after their orientation.

There is an education programme that includes required training. The training attended for 2013 (de-escalation and break away techniques; glucometers; proper use of chemicals; death and dying personal cares and skincare; fire training; wound care; therapeutic touch; manual handling; abuse and neglect; cultural safety; privacy; dignity and choice; medication; infection control/hand washing) and proposed plan for 2014 was sighted. Training on de-escalation techniques is in place. This is an improvement from the previous audit (previous finding 2.1.1.5). Attendance averages 13 – 18 out of a total of 28 staff. In addition to in service training, an online training programme has been implemented over the past six months. Restraint minimisation and safe practice training takes place as an e-learning tool. E-learning was initiated six months ago with six staff completing the restraint minimisation module. This is an improvement from the last audit (previous finding 2.2.3.6) The education programmes provided are relevant to the resident group and issues/trends identified. There are signed attendance records. Staff interviewed (three care givers and the clinical leader) feels there is sufficient training available.

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: PA Low
Evidence: <p>St Clair Park has an orientation programme that provides new staff with relevant information for safe work practice. The orientation programme includes sign-off of a number of areas including: hygiene/grooming, food safety, infection control. In the six files reviewed, completed and signed orientation checklists were sighted in three of the six staff files. Missing were orientation checklists for one RN and two caregiver staff. Three caregiver interviews and the interview with the clinical leader report the time spent orientating new staff is inadequate with the period of induction lasting one day. Caregiver staff report they were 'thrown' into work duties after their orientation.</p>

Finding:

St Clair Park has an orientation programme that provides new staff with relevant information for safe work practice. The orientation programme includes sign-off of a number of areas including: hygiene/grooming, food safety, infection control. In the six files reviewed, completed and signed orientation checklists were sighted in three of the six staff files. Missing were orientation checklists for one RN and two caregiver staff. Three caregiver interviews and the interview with the clinical leader report the time spent orientating new staff is inadequate with the period of induction not long enough. Caregiver staff report they were 'thrown' into work duties after their orientation.

Corrective Action:

Ensure completed orientation checklists are returned and filed. Ensure adequate time is spent orientating new staff to the service.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence: The service has a staff rationale policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The service has three wings (Cargill Wing = thirteen residents; Ash wood Wing = nine residents; Middleton Wing = five residents). The nurse manager reports a casual pool is limited and it can be difficult to cover unexpected absences. Identified staff are willing to work double shifts. The nurse manager is full-time working Monday to Friday. The two RNs (clinical leader and staff RN) work 30 hours a week each (Monday – Friday with RN cover from 0900 to 1800). The RNs share weekend call. The clinical leader reports although she is budgeted at 30 hours per week, she typically works more than 40 hours per week. Caregiver (CG) staffing is as follows (note caregiver staffing includes laundry duties): Cargill Wing AM: (1 CG 0700 – 1500 and 1 CG 0800 – 1300) PM (1CG 1500 – 2315 and 1 CG 1700 – 1930) Ash wood Wing: the same as the Cargill Wing Middleton Wing: (1 CG 0700 – 1500 and 1 CG 0800 – 1000) PM (1CG 1500 – 2315 and 1 CG 1900 – 2100) The night shift is staffed with two caregivers.

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): <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 1.3.3: 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.

Attainment and Risk: PA Low

Evidence:

Residents are assessed prior to entry to the service and a baseline assessment is completed. St Clair Park conducts an assessment of needs on entry of a resident to the service. The registered nurse (clinical leader) confirmed that this includes identification of risks. On the day of the audit, there were 29 residents located as follows in three wings. Cargill, Ashwood and Middleton wings accommodate four rest home residents, 14 mental health residents, six intellectual disability residents, and five physical disability residents throughout the facility. The registered nurses are responsible for conducting assessments and care plan development.

There is a resident admission policy and procedure and a documented procedure for respite resident admission and resident care plan policy.

The long term care plan contains the following headings: medical/surgical history, allergies, activities of daily living, skin integrity, mobility, sleep patterns, nutrition, elimination, pain, identity, orientation and perception, behaviours including risk identification and management plan, de-escalation chart, and a specific lifestyle plan for residents with intellectual disability, and mental health diagnoses.

Those residents with mental health issues have detailed care plans with specific goals in relation to care required promoting wellness and preventing relapse. Two resident files (one mental health, one intellectual disability) reviewed showed input from GP, community mental health team or psychiatry at least once a month, with activities plans. Documentation was evident of resident's involvement in activities away from the facility and independence is promoted as appropriate. One file (mental health) includes a mental health personal plan and goals written 14/7/12, including a risk management plan with early signs for relapse identified, and plan if behaviour changes. Same goals have been reviewed but have no date indicating when this occurred.

D16.2, 3, and 4: The one rest home file reviewed identified that in all four files an assessment was completed within 24 hours of admission. The long term care plan was completed within three weeks.

D16.5e: The one rest home file reviewed identified that the GP had seen the resident within two working days of admission. It was noted that the GP has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools were completed in resident files including (but not limited to); - falls risk, skin and pressure risk, continence, nutrition and behaviours Assessments were completed in July 2012 and have not been reviewed since. (refer 1.3.4)

Tracer Methodology:

Intellectual Disability:

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

Rest Home/Physical Disability:

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

Mental Health:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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>

Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

Attainment and Risk: PA Low

Evidence:

Those residents with mental health issues have detailed care plans with specific goals in relation to care required to promote wellness and prevent relapse. Two resident files (one mental health, one intellectual disability) reviewed showed input from GP, community mental health team or psychiatry at least once a month, with activities plans. Documentation was evident of resident's involvement in activities away from the facility and independence is promoted as appropriate.

Finding:

One file (mental health) includes a mental health personal plan and goals written 14/7/12, including a risk management plan with early signs for relapse identified, and plan if behaviour changes. Same goals have been reviewed but have no date indicating when this occurred.

Corrective Action:

Ensure goals are dated to indicate when reviews occurred

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate

Evidence:

Residents are required to have a needs assessment prior to entry at St Clair Park. One of the four files reviewed contained a needs assessment completed one year prior (1/8/11) to admission date (15/8/12). The resident has an initial registered nurse assessment completed at time of admission and a long term

care plan is developed within three weeks. All equipment required is assessed on the initial assessment and as required thereafter. A range of assessment tools were completed in resident files on admission. All four residents' files have the following assessments - falls risk, skin and pressure risk, continence, nutrition and behaviours. Assessments were completed in July 2012 and have not been reviewed since.

Pain assessment are completed for residents receiving controlled drugs, however resident with chronic pain and receiving regular analgesic (other than controlled medication) has no pain assessment or monitoring occurring to review the effectiveness of his pain relief. This remains a required improvement from previous audit.

Challenging behaviour assessments have been completed for residents with identified challenging behaviour. Specific nutritional assessments have been documented and food and fluid preferences are recorded on the initial care plan and long term care plan.

Documented wound assessments, wound management plan and monitoring documentation has been completed for one resident with a pressure ulcer, the ulcer was present when resident returned from an admission to the Public hospital.

The service gathers information in regards to the resident's culture in the initial assessment and social history with documentation in care plan for any identified factors required to maintain the resident's cultural safety. The service is able to obtain interpreter services as required through the public hospital.

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: PA Moderate

Evidence:

Residents are required to have a needs assessment prior to entry at St Clair Park. One of the four files (rest home/physical disability) reviewed contained a Needs assessment completed one year prior (1/8/11) to admission date (15/8/12). This same resident is to be reassessed with the possibility of being discharged into the community. Registered nurse (clinical leader) confirmed that resident was being assessed for a move to the community; however there was no documentation in regards to this change in care requirements.

A range of assessment tools were completed in resident files on admission. All four residents' files have the following assessments - falls risk, skin and pressure risk, continence, nutrition and behaviours. Assessments were completed in July 2012 and have not been reviewed since. An intellectual disability lifestyle plan was completed in June 2012. Goals and updates have been documented but include no dates to identify when these occurred. Pain assessment are completed for residents receiving controlled drugs, however resident with chronic pain and receiving regular analgesic (other than controlled medication) has no pain assessment or monitoring occurring to ascertain the effectiveness of his pain relief. This remains a required improvement from previous audit.

Challenging behaviour assessments have been completed for residents with identified challenging behaviour. Specific nutritional assessments have been documented and food and fluid preferences are recorded on the initial care plan and long term care plan.

Documented wound assessments, wound management plan and monitoring documentation has been completed for a resident with a pressure ulcer. Documentation identifies that ulcer was present when resident returned from an admission to the public hospital.

Finding:

a) Pain assessment are completed for residents receiving controlled drugs, however resident with chronic pain and receiving regular analgesic (other than controlled medication) has no pain assessment or monitoring occurring to ascertain the effectiveness of his pain relief. b) Assessment tools are used for continence, falls risk, pressure area risk; however these have not been reviewed since August 2012. c) One of the four files reviewed contained a Needs assessment completed one year prior (1/8/11) to admission date (15/8/12). d) An intellectual disability lifestyle plan was completed in June 2012. Goals and updates have been documented but include no dates to identify when these occurred. e) Rest home resident with physical disability is to be reassessed with the possibility of him being discharged into the community. Registered nurse (clinical leader) confirmed that resident was being assessed for a move to the community; however there was no documentation in regards to this change in his care requirements.

Corrective Action:

a) Complete pain assessments for all residents receiving regular analgesia and monitor the effectiveness of pain medication
 b) Review assessment tools as part of the care plan review process 6 monthly prn and update care plan following changes. c) Ensure up to date information is provided prior to admission. d) Ensure lifestyle plan updates are dated to identify when updates occur. e) Document all changes to care needs.

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

Criterion 1.3.4.5 (HDS(C)S.2008:1.3.4.5)

Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Residents receive care that does not restrict their choices within the facility and treatments are authorised by the resident or appropriate other. Care plans are developed within three weeks of admission and include goals/objectives, interventions and evaluation. Care plans include goals and interventions relating to: hygiene needs, mobility, sleep patterns, nutrition, elimination, identity -family involvement, social history expressing spirituality, communication, cultural, and, behaviour.

Initial assessment and information documents that resident weight is to be monitored monthly. In all four files reviewed there were gaps in weight records over the past six months.

Short term care plans are available for acute clinical issues/changes in health status; however these were not evident in any of the four files reviewed.

The facility is equipped to manage residents with mental health issues and challenging behaviours. Residents are able to move about the facility safely.

Nursing offices are locked and are only accessible to staff.

The service provides care to a mixed cohort of residents - aged care, mental health, intellectual disability and physical disability. Residents admitted with mental health diagnoses (currently 14 residents - two interviewed) are cared for with care and support from the staff and allied health providers. The registered nurse advised that the service promotes mental health and wellbeing through a philosophy of promoting resident to be the best they can.

Residents are actively encouraged to maintain relationship with family and friends and are supported to continue activities in the community.

Three caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, pressure relieving mattresses, continence supplies, dressing supplies. There are no lifting devices available other than lifting belts. The nurse manager reports the facility has a 'no lift' policy. Three caregiver interviews state that they understand there is a no-lift policy but continue to assist residents to their feet if a resident has not sustained an injury following a fall, instead of calling an ambulance. Two staff report they injured their backs last year lifting residents who had fallen. (Refer 1.4.2)

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

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

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

There are currently one wound being managed at St Clair Park, wound assessment and management documentation was included in the wound folder. The clinical leader interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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: PA Moderate
Evidence: Care plans are developed within three weeks of admission and include goals/objectives, interventions and evaluation. Care plans include goals and interventions relating to: hygiene needs, mobility, sleep patterns, nutrition, elimination, identity -family involvement, social history expressing spirituality, communication, cultural, and, behaviour. Initial assessment and information documents that resident weight is to be monitored monthly. In all four files reviewed there were gaps in weight records over the past six months. One aged care resident who has been assessed as overweight and requires a low calorie diet. Weights were last documented September and October 2012. It was noted that it was some fifteen days later an antibiotic was charted for a urinary infection. A resident was passing large amount of blood, there was no documentation of Registered nurse follow-up. There were gaps in monthly observations being documented, two residents had no record of observations being taken since August 2012, however documentation stated that this should occur monthly. The facility is equipped to manage residents with mental health issues and challenging behaviours. Residents are able to move about the facility safely. Nursing offices are locked and are only accessible to staff. Residents receive care that does not restrict their choices with in the facility and treatments are authorised by the resident or appropriate other. Clinical care is reviewed at least three monthly and more frequently of required.
Finding: Interventions are not occurring in a timely fashion to ensure that residents receive a desirable outcome for their changes in health status.
Corrective Action: Ensure interventions occur in a timely fashion.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)

The consumer receives the least restrictive and intrusive treatment and/or support possible.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:

- (a) Promote mental health and well-being;
- (b) Limit as far as possible the onset of mental illness or mental health issues;
- (c) Provide information about mental illness and mental health issues, including prevention of these;
- (d) Promote acceptance and inclusion;
- (e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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.

Attainment and Risk: PA Low

Evidence:

There is an activities co-ordinator who delivers the activities programme at St Clair Park. The activities co-ordinator works seven hours per day Monday to Friday. Activities are planned that are appropriate to the capabilities of residents. Participation in activities is voluntary. The activities programme is developed monthly and covers seven days per week. Three of four resident files (one rest home/physical disability, one mental health, and one intellectual disability) reviewed identified that the individual interest checklist and an activity plan had been documented and have been reviewed six monthly. One resident file (intellectual disability) contained no activity checklist or activity plan. Staff indicated he didn't get involved in activity, he kept to himself. Ten residents interviewed (two intellectual disability, three physical disability, three rest home and two mental health) advised that they are satisfied with the programme. The weekly programme is on the main notice board with a reminder notice to residents what the daily programmes are. The residents make input to the programmes with suggestions made at the residents monthly meetings. The range of activities are craft, dominoes, outings, shopping days, access to community activities, walking groups, church services, scrapbooking, photo frame making, reading the daily newspaper, happy hour and jig saw puzzles. A register is kept as to what activities the residents attend. Activities were observed to be in progress during the audit. Previous audit identified that residents in Middleton access the activities in the main unit via outside. This continues, however the service now provides an activity programme in the Middleton Unit, provided by the care staff. (Refer 1.4.2) in regards to management of this issue.

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 Low

Evidence:

Three of four resident files (one rest home/physical disability, one mental health, and one intellectual disability) reviewed identified that the individual interest checklist and an activity plan had been documented and have been reviewed six monthly. One resident file (intellectual disability) contained no activity checklist or activity plan. Staff indicated he didn't get involved in activity, he kept to himself.

Finding:

One resident file (intellectual disability) contained no activity checklist or activity plan.

Corrective Action:

Ensure all residents have an activity plan developed.

Timeframe (days): 60 (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.

Attainment and Risk: PA Moderate

Evidence:

Care plans are developed by the service's clinical leader who also has the responsibility for maintaining and reviewing care plans. An initial assessment and the beginning of the development of the residents care plan is expected to occur during admission. The full care plan is developed within three weeks. Care plans are developed in consultation with other relevant people including residents and where appropriate family/whanau. There was evidence of other allied health services input at the admission process i.e. GP, psychiatrist, mental health nurse, physiotherapy and podiatry. Caregivers complete progress notes at the end of each shift, with RN notes to assist care staff. There is an appropriate hand-over briefing between shifts that staff were able to fully describe. Short term Care plan are available for acute or short term changes in health status, however there was no evidence in the four files reviewed of these being used. D16.4a Care plans for rest home residents, those with a mental health diagnosis, and those with a physical and intellectual disability are evaluated by the registered nurse six monthly or more frequently when clinically indicated. D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Short term Care plan are available for acute or short term changes in health status, however there was no evidence in the four files reviewed of these being used.

Finding:

Short term care plans have not been utilised when acute or short term changes in health occur.

Corrective Action:

Document short term care plan when resident health status changes.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.12: 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.

Attainment and Risk: PA Moderate

Evidence:

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards.

Eleven out of 12 medication charts record prescribed medications by residents' general practitioners or specialist, one chart identified medication instruction sheet had not been signed by general practitioner; these are kept in the medication folders. Medication Administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, prn medication.

Allergies are identified in residents' medication charts and resident files on the front page.

Administration errors are identified as incidents. Medication error in May involving the administration of insulin resulted in the service reporting incident to the DHB. Clinical Leader described the error as a misinterpretation of the medication instruction. DHB visited the service 10/6/12 in regards to this error.

Incident was investigated by the service, identifying staff involved (seven); changes were made to the charting of insulin to ensure clarity of medication instruction. Incident was discussed at staff meeting-5/7/13(minutes sighted); Clinical leader attended a seminar on diabetes management in Wellington in 8/7/13; audit of medication charts completed 10/7/13; discussed again at staff meeting 2/8/13(minutes sighted); 16/8/13 clinical leader has complied completed corrective action report; 30/8/13 all staff have completed medication administration have completed e-learning module with Clinical In-services; diabetic nurse specialist has been involved in assisting the service to develop an improved diabetic care plan for residents with diabetes. However one incident (dated 2 October 2013) relating to a medication error has not been investigated appropriately (link 1.2.4.3)

There is a staff signature identification sheet in the front of the medication folders.

Advised that self-administered medications would be securely stored in locked drawers in the resident's room. Advised there are no residents currently self-medicating.

A local pharmacy supplies medico packs for a four week period. The clinical leader advised that medication packs are checked and reconciled against medication charts upon arrival to the facility and signed off when reconciliation is complete. Any errors are regarded as an incident. The medico packs are stored in a three locked medication cupboards in three locked nurses offices - one in each unit. Medications are brought out at appropriate medication times on medication trolleys (three). Three caregivers were observed safely administering medications - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation. Controlled drugs and a controlled drug register are kept in one locked safe in Cargill unit nurses office, with weekly stock takes by the RN. All staff performing medication administration receive training on medicine management policies and procedures and undergo annual competencies.

D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had reviewed the resident three monthly. Previous audit identified the practice of transcribing was occurring. The service has addressed this shortfall and transcribing no longer occurs. One medication instruction sheet identified medications were not signed for by general practitioner. Six out of twelve charts reviewed identified gaps in signing sheets (eleven times), with no reason documented why medication not given. Administration sheets for controlled medication included two signatures on administration.

PRN analgesia and antipsychotic medications are used in accordance with medication instructions from the general practitioner; however documentation does not reflect the effectiveness of the administration of medication.

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 Moderate

Evidence:

Eleven out of twelve medication charts record prescribed medications by residents' general practitioners or specialist, one chart identified medication instruction sheet had not been signed by general practitioner.

Finding:

One chart identified medication instruction sheet had not been signed by general practitioner.

Corrective Action:

All medication instruction sheets must be signed by residents' general practitioners or specialist

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: a) Six out of twelve charts reviewed identified gaps in signing sheets (eleven times), with no reason documented why medication not given. b) PRN Analgesia and antipsychotic medications are used in accordance with medication instructions from the general practitioner; however documentation does not reflect the effectiveness of the administration of medication.
Finding: a) Six out of twelve charts reviewed identified gaps in signing sheets (eleven times), with no reason documented why medication not given. b) No documentation is completed following the administration of PRN medication to assess effectiveness of medication given.
Corrective Action: a) Document reasons why medication has not been administered and identify on medication administration sheet. b) Document effectiveness or otherwise following administration of PRN medication.

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

Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The Ace food services are contracted to provide food and meals to St Clair Park residential centre. There are systems in place to deal with any issues related to food. Resident's preferences are identified and their nutritional needs are met and a dietitian is consulted where necessary. Any special equipment needed is provided and food handling procedures meet legislation and guidelines. Snacks can be provided between meals if required. Any special equipment needed is available for residents use such as lipped plates and modified cutlery.

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

All food in fridges was appropriately covered and labelled. Temperatures of fridges and freezers are recorded regularly. Staff interviewed were able to describe safe food handling procedures and this is covered as part of staff orientation.

All four files reviewed included nutritional assessments and dietary profiles completed on admission. These have not been reviewed since 2012. (refer # 1.3.4) One resident who has been assessed as overweight and requires a low calorie diet. Weights were last documented Sept and October 2012 (refer # 1.3.8)

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.

Attainment and Risk: PA Moderate
Evidence: There is a locked cupboard for chemicals required for cleaning, however on the day of the audit, the cleaning trolley was left unattended in Cargill area and one chemical dispenser was not labelled with manufacturer label.

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: PA Moderate
Evidence: Previous audit identified in the Middleton wing there was a chemical decanting unit that is in the unsecured laundry room. There is a locked cupboard for chemicals required for cleaning, however on the day of the audit, the cleaning trolley was left unattended in Cargill area and one chemical dispenser was not labelled with manufacturer label.
Finding: On day of audit, the cleaning trolley was left unattended in Cargill area and one chemical dispenser was not labelled with manufacturer label.
Corrective Action: Ensure that all chemicals are stored safely and securely. Ensure all chemicals are labelled with the manufacturer label.
Timeframe (days): 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate
Evidence: The services Building warrant of Fitness (Bwof) expired 6/7/2013. The service has correspondence from Dunedin City Council in regards to the... "receipt of a letter from Southern Fire Protection stating that a form 12A to complete the Bwof for 2012/2013 cannot be produced. The DCC understands that the systems within the building are fully operational. We (DCC) understands that an IQP has been employed to carry out the inspections, maintenance and reporting for the systems on the compliance schedule for the next 12 months. This will allow a properly completed Bwof to be produced next year." Completed inspection documentation was sighted for July, August and September 2013. There are no lifting devices available other than lifting belts. The nurse manager reports the facility has a 'no lift' policy. Three caregiver interviews state that they understand there is a no-lift policy but continue to assist residents to their feet if a resident has not sustained an injury following a fall, instead of calling an ambulance. Two staff report they injured their backs last year lifting residents who had fallen. This previously identified shortfall remains a required improvement. Previous audit identified an improvement was required in regards to there being steps and no ramp between Ashwood and Middleton unit. To access the main area for activities, the residents in wheelchairs have to go outside and up the drive to the main entrance. The service has engaged a builder to assess options available to rectify this issue. Due to the lack of space available in the current building design and the required gradient of a ramp if installed, the

service has looked at alternative measures to remedy this issue. There is only one resident currently residing in Middleton unit who occasionally requires the usage of a wheelchair (she has prosthesis and normally can manage the steps). The service holds an activity programme in Middleton unit (provided by the care staff) and the clinical leader confirmed that the service would not admit prospective residents to this area if accessing the steps was an issue. The on-going maintenance programme include electrical testing and tagging of electrical appliances and equipment, completed 7/12/12. This is an improvement since previous audit.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Moderate
Evidence: The services Bwof expired 6/7/2013. The service has correspondence from Dunedin City Council (DCC) in regards to the “receipt of a letter from Southern Fire Protection stating that a form 12A to complete the Bwof for 2012/2013 cannot be produced. The DCC understands that the systems within the building are fully operational. We (DCC) understands that an IQP has been employed to carry out the inspections, maintenance and reporting for the systems on the compliance schedule for the next 12 months. This will allow a properly completed Bwof to be produced next year.” Completed inspection documentation was sighted for July, August and September 2013.
Finding: The services Bwof expired 6/7/2013.
Corrective Action: Ensure that inspections, maintenance and reporting for the systems on the compliance schedule for the next 12 months occur, to allow a properly completed Bwof to be produced next year.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate
Evidence: There are no lifting devices available other than lifting belts. The nurse manager reports the facility has a ‘no lift’ policy. Three caregiver interviews state that they understand there is a no-lift policy but continue to assist residents to their feet if a resident has not sustained an injury following a fall, instead of calling an ambulance. Two staff report they injured their backs last year lifting residents who had fallen. This previously identified shortfall remains a required

improvement.

Finding:

There are no lifting devices available other than lifting belts. The nurse manager reports the facility has a 'no lift' policy. Three caregiver interviews state that they understand there is a no-lift policy but they continue to assist residents to their feet if a resident has not sustained an injury following a fall, instead of calling an ambulance. Two staff report they injured their backs last year lifting residents who had fallen. Contacting ambulance services when no injury has been sustained is not an appropriate use of external resources. Nor are residents who are uninjured always able to stand unaided following a fall. A no lift policy in a facility where residents fall but do not harm themselves has not proven effective. This remains an improvement from the previous audit.

Corrective Action:

Ensure systems are in place to minimise the risk of harm to staff.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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.

Attainment and Risk: FA
Evidence: Policies and procedures are in place for restraint minimisation and safe practice. The use of enablers is voluntary. Policy defines an enabler as voluntary and the least restrictive option that is chosen to promote resident safety and independence. The clinical leader is the restraint coordinator. Staff are completing education and training in restraint minimisation and safe practice as an e-learning tool. At the time of the audit, six staff had completed this training. This is an improvement from the previous audit (previous PA 2.1.1.5). There are no residents using a restraint or an enabler. The clinical leader reports there have been no instances of restraints used since July 2012. There have been no recorded instances of an enabler being used.

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

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.

Attainment and Risk: FA
Evidence: An approval process is documented to manage restraint activities. There are no residents using a restraint or an enabler. The clinical leader reports there have been no instances of restraints used since July 2012 and she cannot recall if an enabler has ever been used. The clinical leader reports staff are clear that physical restraint is not to be used. This was confirmed in interviews with three caregivers. This is an improvement from the previous audit (previous PA 2.2.1.3).

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

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.

Attainment and Risk: FA
Evidence: The restraint assessment process is defined in policy. There are no residents using a restraint or an enabler. The clinical leader/restraint coordinator reports there have been no instances of restraints used since July 2012 and she cannot recall if an enabler has ever been used. In the event restraint is required, the restraint coordinator is aware that a full assessment will be completed. This is an improvement from the previous audit.

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

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

Services use restraint safely

Attainment and Risk: FA
Evidence: A policy is in place to prescribe the process for approval, assessment and on-going monitoring of restraint. There are no residents using a restraint or an enabler. The restraint coordinator reports there have been no instances of restraints used since July 2012. The restraint coordinator is aware a restraint register is required if restraints or enablers are used. These are improvements from the previous audit (previous PA 2.2.3.1, 2.2.3.3, 2.2.3.4 and 2.2.3.5).

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

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

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

Services evaluate all episodes of restraint.

Attainment and Risk: FA

Evidence:

Procedures are in place for the evaluation of restraint. Staff understand that physical restraint is not permitted. The restraint coordinator reports there have been no instances of restraints used since July 2012. These are improvements from the previous audit.

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

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

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

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.

Attainment and Risk: FA
Evidence: <p>The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control co-ordinator with expert support from external providers who provide the service with current and best practice information. The infection control coordinator has attended external education with 'Bug Control' in 2012 and infection control in service in relation to Hepatitis B&C, ESBL and MRSA have been provided to staff 21/9/2013. This is an improvement from previous audit.</p>

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.)

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: The clinical leader (registered nurse) is the Infection control co-ordinator. Monthly infection control surveillance occurs and analysis of monthly data occurs. Graphs are available with comparisons of 2012/2013 occurring. Regular reporting of infection control issues to the quality meeting occurs. Compliance with infection control practices is evaluated by the IC coordinator through internal audits, the results of surveillance data and observation. Three caregivers interviewed were able to confirm that they were informed at handover by the registered nurse regarding any infection control issues.

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

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