# Presbyterian Support Services (South Canterbury) Incorporated - Wallingford Rest home

## Current Status: 27 November 2013

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

## General overview

Wallingford Rest home is able to provide rest home level care services for up to 32 residents. On the day of the audit there were 29 rest home residents.

The service has an organisational structure that supports the continuity of management and quality of care and support.

The nurse manager at Wallingford has been in the role for two years and is supported by the Elder Care Manager and the Chief Executive Officer (CEO). There continues to be an implemented quality and risk management system in place.

The service has addressed seven of eight shortfalls from the previous certification audit around: recording residents personal belongings, closing the quality loop, management of training records, aspects of medication documentation and competencies, chemical handling training and restraint/enabler training.

Further improvements continue to be required around documentation of advanced directives.

This surveillance audit identified no additional shortfalls.

## Audit Summary as at 27 November 2013

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 27 November 2013

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

### Organisational Management as at 27 November 2013

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

### Continuum of Service Delivery as at 27 November 2013

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

### Safe and Appropriate Environment as at 27 November 2013

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

### Restraint Minimisation and Safe Practice as at 27 November 2013

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

### Infection Prevention and Control as at 27 November 2013

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Presbyterian Support Services (South Canterbury) Inc. |
| **Certificate name:** | Wallingford Rest Home |

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

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| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Wallingford Rest Home, Temuka | | | |
| **Services audited:** | Rest Home | | | |
| **Dates of audit:** | **Start date:** | 27 November 2013 | **End date:** | 27 November 2013 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 29 |

## **Audit Team**

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

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 8 | Total audit hours off site | 6 | Total audit hours | 14 |

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| Number of residents interviewed | 7 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 30 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **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:

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| --- | --- | --- |
| 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 Thursday, 13 February 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Wallingford Rest home is able to provide rest home level care services for up to 32 residents. On the day of the audit there were 29 rest home residents. The service has an organisational structure that supports the continuity of management and quality of care and support . The nurse manager at Wallingford has been in the role for two years and is supported by the Elder Care Manager and the Chief Executive Officer (CEO). There continues to be an implemented quality and risk management system in place.  The service has addressed seven of eight shortfalls from the previous certification audit around: recording residents personal belongings, closing the quality loop, management of training records, aspects of medication documentation and competencies, chemical handling training and restraint/enabler training.  Further improvements continue to be required around documentation of advanced directives  This surveillance audit identified no additional shortfalls. |

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| **Outcome 1.1: Consumer Rights** |
| Open disclosure is inherent in the day-to-day operations of the service. Families report that they are always informed when their family member's health status changes or of any other issues or adverse events arising. Complaints processes are implemented. Complaints and concerns are actively managed and well documented. Previous shortfalls have been addressed and monitored by the service relating to implementation of policy around resident belongings. Further improvements are required relating to documentation of advanced directives. |

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| **Outcome 1.2: Organisational Management** |
| Wallingford Rest Home has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with other similar aged care facilities. Corrective actions are identified and implemented. The service has made improvements in this area. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. The service has addressed and monitored previous findings relating to implementing action plan following resident surveys. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The service has addressed and monitored previous shortfall related to maintaining education records. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| PSSC Wallingford Rest Home has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning, care plan evaluations and that the interventions noted in the care plans are consistent with meeting residents' needs.  A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is an appropriate medicine management system in place. The previous audit identified transcribing of medication orders to care plans and insulin competencies not completed by care staff – this has been addressed and monitored by the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility is purpose built. All building and plant have been built to comply to legislation. The service displays a current building warrant of fitness. The previous audit identified that safe chemical handling training had not been conducted for staff – this has been addressed by the service. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. There are no residents currently on the restraint register as using a restraint or an enabler. Policy states that the use of enablers is voluntary, requested by the resident. The previous audit identified that restraint/enabler minimisation and challenging behaviour education had not been provided. This shortfall has been addressed. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control nurse completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained. All infections are recorded as per standard definitions of infections on a monthly summary. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 18 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 1 | 0 | 0 | 0 |

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|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 59 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
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| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | Two of four files reviewed had incomplete resuscitation decision forms. | Ensure all residents have advanced directives and resuscitation decision forms completed and up to date. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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 1.1.3: Independence, Personal Privacy, Dignity, And Respect **(**HDS(C)S.2008:1.1.3)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified a shortfall around implementing policy relating to residents personal belongings. The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff interviewed (one nurse manager, one registered nurse, one care supervisor, and two care givers) can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. Discussions with seven residents and two relatives identified that personal belongings are not used as communal property. The staff were respectful of entering a resident’s room and gained permission before doing so. A new policy has been developed and is implemented as evidenced in one recent resident admission. A new property list form is completed for all new admissions as evidenced in two recently admitted residents’ files. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality D14.4 Instructions are provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. This is an improvement from the previous audit. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy, a complaints policy and an incident/accident reporting policy.  Four residents and one family members report they were welcomed on entry and were given time and explanation about the services and procedures. Resident/relative meetings occur three monthly. The nurse manager is readily accessible, confirmed in interviews with two caregivers, four residents and one relative.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is provided to residents on entry. D16.1b.ii 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 four family members interviewed state that they are always informed when their family member's health status changes or of any other issues arising. Evidence of open disclosure to the resident and relatives was verified in all accident/incident forms reviewed and in progress notes in four of four files reviewed. A medical/nursing summary form in each resident file also records when families are contacted – following incidents, GP visits and medication changes. |

##### **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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### Standard 1.1.10: Informed Consent **(**HDS(C)S.2008:1.1.10)

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Previous audit identified a shortfall around recording of decision-making process around advanced directives -1.1.10.7. Advanced directives are included in the resuscitation decision policy (SPM.CR.14). The policy provides clear guidelines on gaining advanced directives and is congruent with the Health and Disability Commissioner guidelines. The policy is supported by a dying and bereavement policy (SPM.CR.22). The policy requires that the decision if discussed with the resident/ family regularly. The information pack provided to new residents outlines the resuscitation policy and procedures and review processes. Two of four files reviewed evidenced records of discussion around advanced directives and resuscitation decisions. Two of four files had incomplete resuscitation decision forms. Advised by the nurse manager that there is a process underway for addressing this shortfall. This continues to require improvement. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Advanced directives are included in the resuscitation decision policy (SPM.CR.14). The policy provides clear guidelines on gaining advanced directives and is congruent with the Health and Disability Commissioner guidelines. The policy is supported by a dying and bereavement policy (SPM.CR.22). The policy requires that the decision if discussed with the resident/ family regularly. The information pack provided to new residents outlines the resuscitation policy and procedures and review processes. Two of four files reviewed evidenced records of discussion around advanced directives and resuscitation decisions. |
| **Finding:** |
| Two of four files reviewed had incomplete resuscitation decision forms. |
| **Corrective Action:** |
| Ensure all residents have advanced directives and resuscitation decision forms completed and up to date. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau.  Seven residents and two relatives confirm they are aware of the complaints process and they would feel comfortable lodging a complaint or discussing concerns with the nurse manager if necessary. There is a complaints register that is up to date and includes relevant information regarding the complaint. Verbal complaints are included. A complaints folder is maintained. There have been no complaints lodged to date in 2013. All documentation for previous year’s complaints and feedback including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder. |

##### **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.

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Wallingford is part of the Presbyterian Support South Canterbury services (PSSC). The organisation has three residential homes, provides community services and Family works programmes. PSSC has a very involved board, which includes representatives from the community – clinical and non-clinical. The service is managed by an experienced aged care nurse manager (registered nurse) who has been in this position for two years. There is a strategic plan 2012-2017, which is reviewed monthly at board meetings. The CEO is provider representative for the DHB health of older people for the South Island. This group gives key strategic direction for older person services in the South Island. These key directives link to the service strategic plans Key objectives include the Eden approach. Wallingford provides rest home level care and support for up to 32 residents; on the day of audit, there were 29 permanent residents. The organisation wide business plan 2012-2014 has the key objectives of 1) protect reputation, 2) minimise costs, 3) manage complaints, 4) manage H&S, 5) strategies to reduce risk, 6) risks as opportunities, 7) staff commitment. There is a facility quality plan 2013-2014, and a quality planner. There are documented indicators and targets. Benchmarking occurs with five other facilities. The nurse manager is supported by an Elder Care manager who visits the facility once a month and the nurse manager also attends monthly aged care managers’ meetings.  The nurse manager attends more than eight hours annually of professional development relating to the management of an aged care environment. She has recently attended a leadership course, attends monthly management meetings and attends professional development in services at PSSC. |

##### **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a strategic plan and quality improvement plan that are implemented. The quality system and internal audit programme is designed to monitor contractual and standards compliance and the quality of service delivery. There is a strategic plan for 2012 - 2017 and a current quality plan (2013 -2014). Quality goals include partnership, leadership, person centred, education and training, teamwork, total organisational involvement in quality, risk management, use of measure and information, quality improvement system, and effective communication strategies. The monthly and annual reviews of this programme reflect the service’s commitment to continuous quality improvement. There is an internal audit schedule in place. There is evidence of the regular monitoring of a wide variety of aspects of the service via this internal audit schedule, the education planner and meeting planner. In addition, there is opportunity for each service under PSSC to conduct quality improvement initiatives. An example of a recent quality initiative at Wallingford is improving the outdoor seating and garden area for residents to enjoy the garden and sun areas easily and safely.  Feedback and progress relating to quality and risk management systems is provided during staff meetings and monthly CQI/management meetings at head office. The quality assurance/staff meeting includes (but is not limited to) feedback pertaining to: internal audits; quality initiatives; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; education.  Minutes are maintained and easily available to staff in the staff room (minutes sighted for 23-Aug-13). Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates PSSC Wallingford's commitment to on-going quality improvement. Discussions with one registered nurse, one care supervisor, and two caregivers confirm their involvement in the quality programme. The CQI/managers’ meeting held monthly is where benchmarking, facility reports and policy review is received (minutes sighted for 26-Nov-13).   Resident/relative meetings take place three monthly – minutes sighted for August 2013. Discussion is held around activities, meals, outings, health and safety and Eden principles being implemented at Wallingford.  D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. The reviews of the policies and procedures are scheduled to be completed on an annual basis and are discussed at CQI meetings held at head office.  The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety meetings are held three monthly to discuss hazard management, falls and incidents, and hazard identification. There is a comprehensive infection control manual. There is a restraint policy and health and safety policies and procedures. There is an annual staff-training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.  A document control system is in place. Documents no longer relevant to the service are removed and archived. Policies and procedures that are updated are documented on a document control sheet that is held in the front of each policy manual. The nurse manager reports staff are made aware of policy updates via staff meetings and copies of policy updates are posted in the staff room.   The service collects information on resident incidents and accidents, and staff incidents/accidents. Incident/accident forms are completed and given to a registered nurse who completes the follow up. All incident/accident forms are seen by the nurse manager who completes any additional follow up and collates and analyses data to identify trends. Data is being benchmarked against three other PSSC aged care facilities and two other local aged care facilities.  Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through resident/relative meetings and surveys are followed up and actioned. This is an improvement from the previous audit. Infection control data is collated monthly and reported to staff. One registered nurse, one care supervisor and two care workers interviewed are well informed about infection control. Data is being benchmarked against other aged care facilities. Actual and potential risks are identified and corrective actions initiated. There is a hazard register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually.  Restraint/enabler use is reviewed and reported at the monthly CQI/management meeting at head office and at the three monthly staff meetings. Results of internal audits, reports from incidents and accidents, infection rates, restraint use and health and safety issues are discussed with staff through the three monthly staff meetings. This meeting incorporates discussion around health and safety, resident issues, infection control, education and quality assurance. Staff are able to contribute to the staff meeting agenda and a communication book also records outcomes of audits, and infection rates. The outcomes of audits, infection rates and falls incidence are displayed on the staff room notice board.  A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually. Internal audits are completed and include the identification of any issues and corrective actions where required. Internal audits conducted for 2013 include health and safety, kitchen, laundry, cleaning, privacy, care plans and medication. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored. Resident/relative meetings occur three monthly. Annual resident satisfaction surveys and family satisfaction surveys are completed –last conducted May 2013. The survey attracted an 86% return rate with 98% agreed with the statement that they were happy with the overall quality of the service and 88% agreed with the statement that the service has made a positive contribution to their life. Positive comments were received in relation to meals, staff, making friends, facility being nice and warm and the rest home was ‘a home away from home’. The Eden Alternative Philosophy initiative is implemented with a further four principles now in place addressing loneliness, helplessness and boredom and having the opportunity to do things we find meaningful. . |

##### **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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Discussions with the nurse manager and registered nurse confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications. D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents.  The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident by the individual witnessing the event, with immediate action noted by the registered nurse (RN) on duty and any follow up action required. The nurse manager signs off on all adverse events. Minutes of the staff meetings reflect a discussion of incidents/accidents and actions taken. Seven completed incident/accident forms were randomly selected for review from November 2013 and involved four residents. Investigations are conducted by the registered nurse. Both RN and manager sign the forms when the investigation is completed. Accident and incident forms and records in the medical/nursing summary provide evidence that families are kept informed - and confirmed on family interviews. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Wallingford employs 30 permanent staff. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including registered nurses and general practitioners is kept. Current practising certificates were sighted for all registered health professionals - registered nurses, Occupational therapist, GP and dietitian.  There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Four staff files were reviewed (one registered nurse, one care supervisor and two caregivers). Reference checks are completed before employment is offered and are evident in staff files reviewed. Police vetting is routinely conducted. Signed employment contracts and job descriptions are held at the PSSC head office in Timaru. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers were able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the nurse manager for staff who require additional training. Orientation programmes are specific to the service type (e.g., RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all four staff files audited). PSSC conducts orientation study days for new staff and topics include Valuing the Older Person, dementia and communication, restraint minimisation, manual handling, continence and code of consumer rights education.  Discussion with the nurse manager, one registered nurse, one care supervisor and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an education plan 2012 and 2013. The annual training programme exceeds eight hours annually. Additionally, all caregivers are given the opportunity to undertake external aged care education within three months of commencement of employment. Two caregivers interviewed have both completed the National Certificate in care of the elderly. The registered nurses are able to attend external training including conferences, seminars and sessions provided by South Canterbury District Health Board (SCDHB).   In 2013 (year-to-date) there have been 13 in-service training sessions provided for staff including: restraint (26 staff attended); infection control (21); nutrition (11); fire training; Elder abuse (15); palliative care (2 RN’s); manual handling (23); code of consumer rights and advocacy (22). Fire drill last conducted 25-Nov-2013. Medication education and competencies completed in July 2013 and Insulin administration competencies completed in July 2013. First Aid training for staff conducted in November 2013. Education in 2012 included (but not limited to): fire training, chemical handling, wound care, and informed consent. Efforts are undertaken by the nurse manager to ensure in-service education is regularly attended by staff (evidenced in interviews with the nurse manager, registered nurse, care supervisor, and two caregivers). Education records are maintained and are up to date. The nurse manager maintains comprehensive staff records to identify training needs and attendance. This is an improvement from the previous audit. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a staff numbers, hours and skill mix 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.  Interviews with one registered nurse, one care supervisor, two caregivers, seven residents and two family members identify that staffing is adequate to meet the needs of residents.  The nurse manager works full-time Monday-Friday and there are two part time registered nurses who provide an additional 29 hours registered nursing hours per week. An occupational therapist attends the facility for four hours every three weeks and as required. A physiotherapist is contracted to provide services and assesses all new residents. The roster includes the administrator/care supervisor 40 hours per week, four caregivers on the morning shift (three long shifts and one short); three caregivers on the afternoon shift (two long shifts and one short); and two caregivers on overnight. The Diversional therapist works Monday to Friday. Caregiving staff attend to resident’s laundry and the routine cleaning. Extra staff hours are allocated for specialised cleaning such as steam cleaning and carpet cleaning. The kitchen staff are provided by Alliance caterers. Caregiver staffing fully complement the service meeting ARC contractual requirements. The nurse manager reports staff numbers are adjusted based on resident acuity and the occupancy rate. |

##### **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.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff (one registered nurse and one nurse manager) were familiar with the timeframes and files reviewed were kept up to date. InterRAI assessment tool is not currently in use; however, the registered nurse advised that she is booked in to attend InterRAI training in early 2014.  D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours. A long-term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months.  D16.5e; Medical assessments were documented in four of four long-term files reviewed within 48 hours of admission. Three monthly medical reviews were documented in all four files by a general practitioner. It was noted in all four resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly. On interview the GP advised that residents are seen three monthly or more frequently if required. More frequent medical assessment/ review noted occurring in residents with acute conditions. Assessment tools available for completion on admission include a) pressure area risk assessment, b) pain assessment and pain charts, c) challenging behaviours and monitoring forms, d) continence assessment, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly. Annual clinical reviews are conducted for all residents and include input from the GP, RN, physiotherapist, occupational therapist, family and other allied health professionals.  Wound care assessments and treatment plans were reviewed and included two residents with wounds – one skin tear and one head wound. Short-term care plans have been developed for wound management. A lifestyle care plan is used for activities with activities assessments, client profile, activities records and six monthly evaluations completed by the diversional therapist.  Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. GP’s from three medical practices in Temuka provide the service with visits to residents. On interview, the GP (with majority of residents) advised that he visits the service weekly. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Four files reviewed evidence this is occurring. The physiotherapist visits and assesses all new residents and attends as required. An occupational therapist visits the facility and assesses residents also. The GP interviewed stated that the service is prompt at informing of changes in the residents conditions and that instructions are carried out.  Tracer Methodology: Rest home resident. XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

##### **Criterion 1.3.3.1 (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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Four resident files were reviewed. Care plans are individualised and personalised to reflect needs, goals and outcomes on both the daily care interventions and the integrated care plan. Of the four files reviewed, three of those residents were interviewed and all three reported their needs were being appropriately met. The daily care interventions form includes: personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture, medication, controlling pain, sleeping patterns/rest, intimacy/sexuality, communication, memory loss/confusion, challenging behaviour. The integrated care plan identifies specific care needs for each resident and includes problem/need, objectives, interventions, evaluation for identified issues. Care plans were current and interventions reflect the assessments conducted and the identified requirements of the residents. Interview with one registered nurse and one nurse manager verified involvement of families in the care planning process. There were short term care plans in four of four files reviewed and include plans for infections, wounds, skin tears, pain management, changes in health status, return from acute care including post-operative care. Two residents with wounds demonstrate a link between short term care planning and wound management plans. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. Wound assessment and wound management plans are in place for two residents and include one skin tear and one head laceration. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. One resident with chronic mental health issues receives input from the psychogeriatric AT&R service. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an occupational therapist who attends the service for four hours every three weeks and a Diversional Therapist (DT) who works Monday to Friday for 35 hours per week. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day are displayed on a notice board. A client profile and activities assessment is completed on admission, which forms the basis for the diversional therapy plan. The plan includes goals and ambitions as well as a plan of meaningful activities. The resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities documentation. The programme is evaluated and can be individually tailored according to resident’s needs.  The DT advised that residents are able to participate in community activities as well as activities in the service itself. Activities include (but not limited to): outings, exercises, walking bus, gardening, happiness club, housie, happy hour, seasonal celebrations, making pickles and jams, crafts, painting, knitting and sewing, bowls, individual one to one time, weekly church services, newspaper reading by a volunteer. Residents were observed participating in newspaper reading, a church service and gardening. One on one activities are provided for residents less mobile and able. Resident meetings are held three monthly with feedback relating to activities provided at the meeting  All seven residents and two family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Four of four care plans reviewed evidenced that the entire care plan evaluations are comprehensive, relate to each aspect of the daily care interventions and integrated care plan and record the degree of achievement of goals and interventions. Care plans reviewed are updated as changes are noted in care requirements. Short-term care plans are well utilised for residents. Any changes to the long-term care plan are dated and signed. Four of four care plans reviewed included handwritten updates to the plan as needs have changed for certain aspects of the plan.  Short-term care plans were sighted for wounds, infections, pain management, and short-term health issues.  D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated D16.3c: All initial care plans were developed with 24 hours of admission and 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service uses individualised medication blister packs. The medications are delivered monthly and checked in by a registered nurse. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications.  A care supervisor was observed administering medications to the residents, and followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in a locked treatment room. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. Previous audit identified that transcribing was occurring on care plans – no evidence of transcribing on eight of eight medication administration-signing sheets or on four of four care plans reviewed. The service has made improvements in this area. Controlled drugs are stored in one locked safe and cupboard inside the locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly and stock take is conducted six monthly. Medication fridge’s are monitored daily and recorded weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies (or nil known allergies) are recorded on all eight-drug charts reviewed. An annual medication administration competency is completed for RN’s and care givers. Insulin administration competency has been developed and is now utilised – competencies sighted for all staff with medication administration responsibilities. The service has made improvements in this area. There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available. There are currently no residents who self-administer medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. 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) able to meet acceptable good practice standards. As required medication orders (PRN) all record indications for use. D16.5.e.i.2; Eight medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

##### **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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| PSSC contract the provision of food services. The meals are prepared and cooked in the Wallingford facility kitchen. The Food Service Manager, located at 'The Croft' has been in the role for over twenty years and is a qualified chef, and has NZQA implementing food safety qualifications. Alliance food service employs the staff at Wallingford and includes cooks, and kitchen hands. All staff have Food Safety Certificates (NZQA US.167). The Alliance food service has an accredited Food Safety Programme (HACCP), which expires on 20-May-2014. The four weekly winter and summer menu is designed by the Food Service Manager and reviewed by a registered dietician. Menu review conducted April 2013. The kitchen in Wallingford is well appointed with a combi-steam oven, electric hobs, a large fridge and a large freezer, a store room and pantry. The kitchen has a whiteboard, which record the needs and requirements of residents - pureed, reduction, low-fat, vegetarian, diabetic, and residents receiving supplements.  The food service is notified of dietary requirements via a dietary requirements form, which is completed by the registered nurse. It includes likes and dislikes, modified diets and preferences. Food is served in to Bain Marie’s in the large dining room. The facility has recently introduced self-service for residents, which has been well received. Those residents who do not wish to self-serve or who are unable to, are served by the care staff. A daily consolidated sheet is where staff record hot food temperatures prior to serving, cook-chill recordings and fridge and freezer temperatures. These were sighted. Food stored in the fridge and freezer is covered and labelled with a day of the week sticker. Advised that left over food is stored for 48 hours then discarded. The kitchen has a large pantry with extra food stores - enough for three days if required in an emergency.  A registered dietitian conducts nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues. This was evident in four files reviewed. Dietary information is documented in the daily care interventions, and in the integrated care plan if there is an identified nutritional issue.  Resident weights are monitored monthly or more frequently if required.  The daily menu is posted on the hall way notice board. Resident satisfaction survey, which includes food and meal service, was conducted in May 2013. Food and meals are agenda items at the three monthly resident meetings. The service provides feedback forms in each PSSC facility specific for food service - "food for thought' - which provides residents and families further opportunities for feedback on meal service |

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

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

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

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

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

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

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

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

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

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

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

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

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented policies and procedures in the Infection control programme, which relates to hazard and waste management: blood/serum/body fluid/needle stick protocol and reporting forms; management of blood/body fluid spills; disposal of waste. The health and safety manual includes management of incidents and accidents, and incident reporting and analysis. All accidents/incidents are reported on the accident report form and followed through appropriately and discussed at quality meetings and staff meetings. Previous certification audit identified that safe chemical handling training had not conducted since 2009. (#1.4.1.4). Safe chemical handling training has been provided on 31-July-2012 and covered management of hazardous waste. Waste and hazardous substances training included in infection control training and at orientation of new staff. Caregivers (two), a registered nurse and care supervisor are able to describe the safe handling of waste - hazardous and non-hazardous. All accidents/incidents are reported on the accident/incident report form and followed through appropriately and discussed at staff meetings, CQI/management meetings, and health and safety meetings. Chemicals are stored safely in a locked storage room. This is an improvement from the previous audit. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service displays a current building warrant of fitness, which expires on 1-June 2014. Fire evacuation scheme is current and is dated 1-Nov-2010. Fire drill last conducted on 25-Nov-2013. |

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

All buildings, plant, and equipment comply with legislation.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint minimisation is overseen by a restraint coordinator who is a registered nurse (PSSC Elder Care manager). There are currently no residents identified as requiring restraint or enablers. Policy states that the use of enablers is voluntary and is requested by the resident. Restraint/enabler training is included in the in-service training plan for 2012/2013 – last conducted on 21-Nov-2012. The staff orientation study day held for all new and existing staff contains a session on restraint minimisation. Staff complete a questionnaire on restraint minimisation and safe practice. The service has made improvements in this area. |

##### **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.

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

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

#### Standard 3.5: 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance is an integral part of the infection control programme and is described in PSSC Wallingford's infection control policy. The Surveillance Policy describes and outlines the purpose and methodology for the surveillance of infections. The IC Co-Coordinator (PSSC Infection Control nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service. The service utilises benchmarking within PSSC facilities and programmes on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility Infection surveillance is an integral part of the infection control programme and is described in the infection control policy.  Monthly infection data is collected for all infections. All infections are entered on to an infection register. This data is monitored and evaluated. Outcomes and actions are discussed at the three monthly staff meetings and at monthly CQI/management meetings. Emergent issues are discussed at handover, recorded in the communication book and information and data is displayed on the staff notice board. |

##### **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.

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

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

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

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