

# Aberleigh Rest Home Limited

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Current Status: 13 January 2014

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

Aberleigh Rest Home and Dementia Care is one of eight aged care facilities operated by Dementia Care New Zealand. Aberleigh is managed by an operations manager with support from a clinical manager, two directors, education coordinator, quality systems manager, and a regional clinical manager. The service is certified to provide hospital, medical and rest home level care for up to 62 residents and includes hospital, rest home, dementia specific and psychogeriatric care.

On the day of audit, the occupancy was 44 residents.

The service has addressed four of five shortfalls from the previous verification audit around code of compliance certificate following rebuilding work - securing the psychogeriatric wing, completing the garden area, monitoring hot water temperatures in the new wing, and ensuring that the call bell system is working.

Further improvements are required relating to obtaining an approved fire evacuation scheme. One shortfall from the previous certification audit has been addressed relating to signing of medication charts.

This audit identified two further improvements required relating to recording all interventions and conducting assessments for pain issues.

## Audit Summary as at 13 January 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained

Indicator	Description	Definition
	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 13 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 13 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 13 January 2014

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 low risk.
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### Safe and Appropriate Environment as at 13 January 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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### Restraint Minimisation and Safe Practice as at 13 January 2014

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 13 January 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## 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

<b>Legal entity name:</b>	Aberleigh Rest Home Limited		
<b>Certificate name:</b>	Aberleigh Rest Home Limited		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Aberleigh Rest Home and Dementia Care		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia specific; Hospital services - Psychogeriatric		
<b>Dates of audit:</b>	<b>Start date:</b> 13 January 2014	<b>End date:</b> 14 January 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			44

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	11	Total audit hours	35
Number of residents interviewed	6	Number of staff interviewed	12	Number of managers interviewed	4
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	4
Number of medication records reviewed	14	Total number of staff (headcount)	36	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	4			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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited 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)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Friday, 14 February 2014

## Executive Summary of Audit

### General Overview

Aberleigh Rest Home and Dementia Care is one of eight aged care facilities operated by Dementia Care New Zealand. Aberleigh is managed by an operations manager with support from a clinical manager, two directors, education coordinator, quality systems manager, and a regional clinical manager. The service is certified to provide hospital, medical and rest home level care for up to 62 residents and includes hospital, rest home, dementia specific and psychogeriatric care.

Current occupancy is 44 residents – 21 rest home, five hospital, 15 dementia and three psychogeriatric residents. There were two rest home respite residents on the day of audit.

The service has addressed four of five shortfalls from the previous verification audit around code of compliance certificate following rebuilding work - securing the psychogeriatric wing, completing the garden area, monitoring hot water temperatures in the new wing, and ensuring that the call bell system is working. Further improvements are required relating to obtaining an approved fire evacuation scheme.

One shortfall from the previous certification audit has been addressed relating to signing of medication charts

This audit identified two further improvements required relating to recording all interventions and conducting assessments for pain issues.

### Outcome 1.1: Consumer Rights

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

### Outcome 1.2: Organisational Management

The quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. Aberleigh has a current business and quality plan to support quality and risk management at each facility. Aberleigh implements an internal audit programme and collates data for comparisons against other Dementia Care NZ facilities. There is a benchmarking programme in place across the organisation as well. Resident/relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents. The service has a documented training plan.

### Outcome 1.3: Continuum of Service Delivery

A registered nurse is responsible for each stage of service provision. The development of the nursing care plans, activity plans and evaluations are reviewed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of

care. Three monthly multidisciplinary reviews involve the GP, allied health professionals and resident/family. There is an improvement required around the management of dietary supplements and pain assessments.

The activity team provide separate activity programmes for the rest home and hospital and dementia/psychogeriatric care. The seven day a week programme and individual activities are appropriate to the resident's physical and cognitive needs and level of care. There are regular physiotherapy, podiatry and dietitian visits to the service. Local GPs are contracted to provide a medical service for the residents. There are regular visits and support provided by the community mental health team and psychogeriatrician.

There is a robust medication system that meets legislative requirements. Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification allergies and special instructions for administration.

Food services and all meals are provided from the main kitchen on site and delivered in hot boxes to the home kitchenettes. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24 hour period. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

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

The facility displays a current building warrant of fitness. The fire evacuation scheme for the new dementia and psychogeriatric units has yet to be approved by the New Zealand Fire Service. The current fire evacuation scheme was approved in May 2008 for the original buildings. A certificate for public use has been issued by the Marlborough District Council for the completed building work. The service has addressed the requirements identified at previous verification audit relating to security prior to opening the new psychogeriatric unit and completion of the outside environment.

#### **Outcome 2: Restraint Minimisation and Safe Practice**

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has six residents assessed as requiring restraint in the form of one lap belt and T-belt, one handholding and T-belt, two T-belts and two hand holding if required – all in the dementia and psychogeriatric units. There are no residents assessed as requiring enablers. There is an up to date restraint register. Restraint use is monitored and reviewed. Education and competencies are completed in relation to restraint minimisation and challenging behaviour management.

#### **Outcome 3: Infection Prevention and Control**

The infection control nurse at Aberleigh completes a monthly infection summary which is discussed at quality and infection control meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	16	0	2	0	0	0
<b>Criteria</b>	0	42	0	2	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	32
<b>Criteria</b>	0	0	0	0	0	0	0	57

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Low			
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 Low	i) Dietitian progress notes advise protein shakes for two residents referred for weight loss. There is no evidence of dietitian instructions linked to the care plan, resident protein shake list in the kitchen or nutritional supplement signing sheet. ii) There are no pain assessments completed for two	i) Ensure instructions are implemented as per dietitian recommendations. ii) Ensure pain assessments are completed on admission for identified pain and new episodes of pain.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				newly admitted psychogeriatric residents on regular/prn medication for documented pain episodes in a) behaviour chart and b) progress notes.		
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.3	Where required by legislation there is an approved evacuation plan.	PA Low	The business project manager advised that approval for the new fire evacuation scheme has been applied for with the New Zealand Fire Service (NZFS), however, the facility is waiting for the installation of one more fire door in order for approval to be granted.	Provide evidence that the NZFS has approved the new fire evacuation scheme.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding



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

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## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or registered nurses and a copy of any incident relating to individual residents is included in the clinical file. The incident form and or progress notes records that families are informed following incidents or accidents or if there is a change in resident condition (confirmed by five relative interviews – one rest home, one dementia and three psychogeriatric). Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in clinical files and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet.

D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet. A site specific introduction to dementia and psychogeriatric units booklet provides information for family, friends and visitors visiting the facility is included in the admission pack.

D16.4b Residents (six) and relatives (five) interviewed confirmed they are kept fully informed.

D11.3 The admission booklet is available in large print and can be read to residents if required.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within an electronic complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. A complaints folder contains all documentation for the eight complaints received for 2013 – including one health and disability commissioner’s office complaint. This complaint has been appropriately managed with a letter of resolution received from the health and disability commissioners office. Details of the management of the complaints is recorded including letters of follow up and response. Complaints are discussed at the monthly quality management meetings, at organisational level and at weekly team meetings.</p>

D13.3h. a complaints procedure is provided to residents within the information pack at entry.

E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Aberleigh rest home and dementia care is one of eight other facilities and is part of Dementia Care NZ. There is a business plan that includes strategic directions (2013-2014). The governance structure includes two owners/directors. Aberleigh is managed by an operations manager and a clinical manager. Managers from all facilities report monthly to the directors of Dementia Care NZ. The operations manager has been in the role for six months prior to this she worked as the operations coordinator for the period of one year, and before that worked at Aberleigh as a care giver. She has qualifications in management and dementia care. The clinical manager (registered nurse) is responsible for the clinical oversight of the service. The clinical manager was on annual leave and was unable to be interviewed. The organisation's education coordinator (registered psychiatric nurse) was covering the role of clinical manager. The operations manager is also supported by an organisational quality systems manager, and a regional clinical manager.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Dementia Care NZ has a business plan for July 2013 – June 2014 which covers all eight homes. The company's strategic service goals include implementing the vision and values, providing specialist dementia care, providing a homely atmosphere, education and training for staff, education and support for family, and be proactive and adaptive to change. Aberleigh business plan includes goals around services, health and safety, human resource management, occupancy, finance, buildings, administration, and quality and risk management. The quality and risk management plan includes 39 goals and objectives which relate to all aspects of provision of services at Aberleigh. The operations manager reports daily to the owners/directors of Dementia care NZ. A quality systems manager provides quality management support to the operations manager with updates and reviews of policy manuals and oversees the quality management programme. Quality improvement initiatives for Aberleigh have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. These are reviewed at the monthly quality management meetings for effectiveness of implemented actions. Dementia care NZ facilities are part of the QPS benchmarking programme with feedback provided three monthly on data provided to the benchmarking system. A report, summary and areas for improvement are received and actioned.</p> <p>Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.</p> <p>Progress with the quality and risk management programme is monitored through the monthly quality meetings, weekly team meetings, monthly health and safety meetings, monthly registered nurse meetings and monthly infection control meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, complaints, and health and safety. The monthly quality committee meeting agenda includes (but is not limited to): previous meetings minutes and outstanding issues, reports re: internal audits, infection control, health and safety, incidents and accidents, staff, family interaction, clinical report, marketing, activities and education. Minutes are maintained (sighted for 21 November 2013) and staff have access to these meeting minutes in</p>

the staff room (confirmed by four care givers at interview). Registered nurse meeting agenda covers clinical issues, medication errors, education sessions and general business. Minutes for all meetings include actions to achieve compliance where relevant and quality improvements are initiated. This, together with staff training, demonstrates Aberleigh's commitment to on-going quality improvement. Discussions with three registered nurses and four care givers confirm their involvement in the quality programme. Resident/relative meetings take place monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for 2nd December 2013.

There is an internal audit schedule. It includes (but is not limited to): operations audits covering complaints, environmental safety, kitchen service, laundry, staff files, privacy of information; and clinical audits covering general practitioner care, infection control, medication management, pressure area assessment, resident care, resident files, care planning, and restraint.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the resident care plans. The directors, quality system manager and regional clinical managers are responsible for development and review of policies and procedures. Death/Tangihanga policy and procedure in place that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. There are procedures to guide staff in managing clinical and non-clinical emergencies and there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, falls review, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care givers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the clinical manager and operations manager who complete any additional follow up. The operations manager collates and analyses data to identify trends. Results are discussed with staff through the monthly health and safety meetings, monthly quality meetings, and weekly team management meetings, and provided to QPS benchmarking. Internal audits for 2013 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey (collated January 2013) and a family/EPOA survey (collated January 2013) is conducted annually. The surveys evidence that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via meetings and newsletter sent to all family with the survey outcomes. Corrective actions and quality improvements are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, monthly health and safety meetings, and weekly team management meetings, including actions to minimise recurrence. Falls, medication errors and skin tears are reported and benchmarked through QPS programme. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and four family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incidents for December 2013 for four residents were reviewed and included falls, skin tears, head laceration and behaviours. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the clinical manager. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Medication errors are also reported. An electronic monthly summary of accidents and incidents is compiled by the operations manager with subsequent analysis and investigations. Trends and corrective actions are developed for staff to continue to improve on falls rates and to implement actions for falls prevention. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Staff are informed of incidents and accidents and actions to prevent reoccurrence through communication books, hand over times and have access to meeting minutes.</p>

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

### **Evidence:**

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, dietitian, podiatrist, pharmacists and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (operations manager, clinical manager, one registered nurse/ infection control nurse, and two care givers. Advised that reference checks are completed before employment is offered as evidenced in two recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four care givers interviewed (who work across all four service areas) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in five of five staff files reviewed.

Interviews with the registered nurses and 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 a completed in-service calendar for 2013 and a plan in place for 2014. The annual training programme exceeds eight hours annually. Caregivers have completed either the national certificate in care of the elderly or are working towards completion. All care givers are expected to complete the dementia unit standards – with 21 of 26 care giving staff having completed and five staff working towards completion. Care givers work across all service levels at Aberleigh. The diversional therapist and activities staff working in the special care unit have completed ACE dementia modules. The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

The operations manager and clinical manager, and registered nurses attend external training including conferences, seminars and sessions provided by the local DHB, the organisation and the New Zealand Aged Care Association. The operations manager has attended the organisations management training day in April 2013. Education provided in 2013 includes but not limited to: manual handling, medication management, falls prevention, clinical assessment, first aid, restraint minimisation, dementia and managing, challenging behaviours,, continence, pressure area management, palliative care, abuse and neglect, pain management, infection control, wound management, and chemical safety.

Dementia care NZ also has a number of competency packages which have been developed for care staff and registered nurses. Staff complete self-directed learning packages if they are unable to attend education sessions. There are compulsory competencies for staff which include medication, restraint minimisation, non-violence crisis interventions, infection control, cultural awareness, abuse and neglect, chemical safety, first aid, and fire safety. Registered nurses also complete specific competencies around medications, assessments, delirium, neurological care, and skin and pressure area care. All staff are encouraged to complete the service's 'best friends approach to care' package which is aimed at providing staff with the skills to care for residents as their 'best friend'. The education coordinator (acting as clinical manager on the days of audit) maintains a spread sheet to record all education provided, attendance and competencies completed. Families are also provided with education and support with two programmes offered - 'orientation for families' and 'sharing the journey'. These programmes are designed for dementia resident's families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours.

Fire drill and fire safety education provided in August 2013. Annual appraisals are conducted for all staff as evidenced in five of five files reviewed.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in place and show staff coverage across the rest home/hospital units, dementia unit and psychogeriatric unit. There is a registered nurse on duty in the rest home/hospital unit 24/7. A second registered nurse is employed to cover the morning shift – Monday through Sunday. This registered nurse is available for dementia and psychogeriatric residents. Sufficient staff are rostered on to manage the care requirements of the residents. A minimum of four staff are rostered on at any one time. The operations manager works full time and the clinical manager works full time – three days clinical administration and two days as a rostered registered nurse. Each unit has its own roster. Care givers work a mixture of short and long shifts and complete cleaning and laundry duties. Other staff include diversional therapist and activities staff, kitchen staff and maintenance and gardening staff. Interviews with three registered nurses, four care givers, six residents and five family members identify that staffing is adequate to meet the needs of</p>

residents.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Aberleigh rest home provides a caring homely environment for its residents. The service provides rest home, hospital, dementia and psychogeriatric level of care. The 20 dementia care beds are divided into two "homes", Rata and Matai. The newly opened six bed psychogeriatric unit is the only unit available in Blenheim for psychogeriatric care.</p> <p>The staff are committed to valuing each resident as an individual and practice the "best friends" approach to care and activities. Establishing relationships with families is achieved with community visits and bringing together families through "sharing the journey" family support groups. Guest speakers such as lawyers, age concern and Alzheimer's speakers attend the meetings. Relatives interviewed (one rest home, three psychogeriatric and one dementia) spoke highly of the management and staff, the care, activities programme, medical care and the environment.</p>

D16.2, 3, 4. One hospital, one YPD (younger person), one rest home, two dementia files and one psychogeriatric file sampled, identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks. There is documented evidence that the rest home and dementia care plans are reviewed six monthly by a registered nurse (RN) and amended when current health changes. Care plans in the hospital and psychogeriatric units have care plans evaluated three monthly or sooner when current health changes. There are three monthly multidisciplinary team (MDT) reviews for all residents in hospital level of care and six monthly multidisciplinary (MDT) reviews for all residents in rest home level care.

D16.5e; Six resident files sampled identified that the general practitioner (GP) had seen the resident within two working days. It is noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly or more frequently should the residents health status change.

The resident may retain their own GP. There are several GP clinics with GPs who visit three monthly for routine three monthly medical examination and medication reviews. The RN faxes the GP if there are any resident concerns and a GP visit is scheduled generally at the end of the day or early morning. Locum cover is provided as required for GP leave. Residents transferring into the region have been able to enrol with a local GPs. The GP's operate an after-hour's clinic at the local DHB and are readily available for advice or visits. Residents requiring urgent medical attention are transferred by ambulance to the emergency department for assessment and treatment. The regional clinical manager (interviewed) is satisfied with the GP service provided for the residents at Aberleigh. The main GP (interviewed by phone) spoke positively about the care and level of services provided at Aberleigh. The RN's are knowledgeable about the resident conditions and assist the GP during the routine and after hour's visits.

The physiotherapist visits fortnightly and completes the initial assessments and mobility plans for new residents, attend MDT reviews, and follow-up any concerns/referrals regarding deteriorating mobility, assessment/purchase of equipment. The podiatrist visits six weekly.

The dietitian visits monthly and is involved in resident reviews where applicable and readily available (by visit and email) to the clinical and food services team for any advice or resources. Allied health professionals record visits in the integrated notes. Nurse specialists such as wound, continence, community mental health nurses are accessed through the local DHB.

The hospice nurses and specialists visit residents under their care for specific needs and palliative cares. Liverpool care pathway is in place for end of life cares at Aberleigh rest home and hospital. RN's have attended end of life education and syringe driver training.

Four caregivers and three RN's interviewed described verbal and written handovers. The information given at handover is sufficient to provide continuity of care to the residents and includes and significant events such as incidents/accidents, changes in condition, GP visits and medication changes. A communication log is used between all staff for general memos. The RN's state caregiver progress notes are reviewed and evidenced by a review stamp. The caregivers are very prompt in reporting any resident health changes or incidents. A resident daily hygiene cares and bowel chart is maintained for every resident. There are daily security check lists maintained.

ARHSS D16.6; One residents file sampled with behaviours that challenge is reviewed. Behaviours is well identified through the assessment process, 24 hour MDT management plan, resident behaviour chart and behaviour monitoring.

The community mental health/psychiatric nurse visits at least weekly and liaises closely with the clinical manager/RNs, GP and the psychogeriatrician based at Nelson.

The community mental health/psychiatric nurse (interviewed) confirms the psychogeriatrician is readily accessible. The psychogeriatrician visits four to six weekly. There is evidence in the medical notes of GP communication with the psychogeriatrician in regards to medication review.

The organisational education coordinator is a trained psychiatrist nurse and is readily available to staff for advice, education and staff debriefs as required.

Tracer methodology; Rest home resident

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

Tracer methodology; Hospital resident

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

Tracer methodology: Dementia care resident

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

Tracer methodology: Psychogeriatric 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity staff and management. The care plans are well written, in-depth and reflect the service philosophy of care and support. Relatives interviewed states their relatives needs are being met. The staff and facilities are appropriate for providing rest home, hospital, dementia and psychogeriatric services.

D18.3 and 4 . Wound assessments are comprehensive and include type, location and body map/graph, photograph as applicable, Braden score, cause, classification, factors delaying healing and any additional information such as referrals. A wound dressing schedule describes dressing types, objectives and reviews.

There are wound assessment plans and wound dressing schedules in place for a skin tear, and a chronic wound (present on admission).

There are no pressure areas. Pressure area resources are available as required. There is evidence of district nursing involvement in the management of the chronic wound. Continence management advice is available as needed (through the DHB) and this could be described by the regional clinical manager interviewed. Adequate dressing supplies are sighted. A skin tear kit is readily available for staff to access.

Continence assessments include a urinary and bowel continence assessment are completed on admission and reviewed three monthly. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained. The company has recently appointed a continence resource person who will visit the facility and provide training.

ARHSS D16.6; One residents file sampled with behaviours that challenge is reviewed. Behaviours is well identified through the assessment process, 24 hour MDT

management plan, resident behaviour chart and behaviour monitoring.

The community mental health/psychiatric nurse visits at least weekly and liaises closely with the clinical manager/RN's, GP and the psychogeriatrician based at Nelson. The community mental health/psychiatric nurse (interviewed) confirms the psychogeriatrician is readily accessible. The psychogeriatrician visits four to six weekly. There is evidence in the medical notes of GP communication with the psychogeriatrician in regards to medication review.

Pain assessments (and Abbey pain scale) are available for the assessment of identified pain on admission, new episodes of pain and for residents on regular or prn medication. Pain assessments and ongoing pain monitoring is evident in the rest home, hospital and dementia files sampled. Pain management and pain relief is reviewed three monthly by the GP and MDT team. There is requirement to complete pain assessments for residents in the psychogeriatric unit (sample extended by another file assess use of pain assessments) where known or identified through behaviour monitoring. The initial physical assessment has recently been formatted to include a section on pain assessment.

The dietitian visits monthly and completes any resident reviews due and attends to any referrals received for example residents with weight loss, initiates special authority for supplements and liaises with the RN regarding any resident dietary changes/requirements. Residents are weighed monthly or more frequently as per the weight loss management policy. The dietitian maintains progress notes in the integrated resident file. Staff record food and beverage intake on recording charts. Prescribed dietary supplements administered are signed on the nutritional supplement signing chart in the medication folder. There is an improvement required around the implementation of dietitian instructions.

Frequent falls physiotherapy assessments are carried out as required. A communication book is used between the RN's and physiotherapist. Falls risk and interventions are well documented in care plans that include sensor mats, hip protectors, adequate hydration, clutter free environment and good fitting shoes. Mobility and handling plans are reviewed regularly to guide the staff in the safe transfer of residents. Frequent fallers are reviewed by the MDT team. Use of psychotropic medications have been reduced to minimise side effects and are monitored by the GP, geriatrician and psychiatric team.

Monitoring forms in use included behaviour monitoring, weight monitoring, food and fluid monitoring and AWOL charts. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, and medication requests sighted in the resident files sampled. Daily walking resident at risk charts are in place that identify the clothing being worn for that day.

Significant events record relative/EPOA contact or discussion such as care plan reviews, infections, incidents/accidents, GP visits, allied health professional visits, medication reviews and any changes in resident health status.

Challenging behaviour assessments are well documented with excellent follow up into care plans for the psychogeriatric resident files sampled and one rest home resident file with identified behavioural problems. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques. All resident files sampled have a 24 hour MDT (multidisciplinary) care plan that details the resident's morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation.

ARHSS D16.4; Strategies for the provisions of a low stimulus environment could be described by the care team and diversional therapist.

### **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 Low

**Evidence:**

The dietitian visits monthly and completes any resident reviews due and attends to any referrals received from the RN for any resident concerns. The dietitian maintains

progress notes in the integrated resident file with suggestions/instruction for dietary changes. However, the care plan is not updated. Dietary supplements (prescribed and non-prescribed) administered are signed on the nutritional supplement signing chart in the medication folder. Pain assessments (and Abbey pain scale) are available for the assessment of identified pain on admission, new episodes of pain and for residents on regular or prn medication. Pain assessments and ongoing pain monitoring is evident in the rest home, hospital and dementia files sampled with identified gaps in the psychogeriatric unit.

**Finding:**

- i) Dietitian progress notes advise protein shakes for two residents referred for weight loss. There is no evidence of dietitian instructions linked to the care plan, resident protein shake list in the kitchen or nutritional supplement signing sheet.
- ii) There are no pain assessments completed for two newly admitted psychogeriatric residents on regular/prn medication for documented pain episodes in a) behaviour chart and b) progress notes.

**Corrective Action:**

- i) Ensure instructions are implemented as per dietitian recommendations.
- ii) Ensure pain assessments are completed on admission for identified pain and new episodes of pain.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The company Diversional Therapy (DT) Coordinator is employed for four days as a DT and oversees and supports the activities teams in all Dementia Care NZ. facilities. The activity team of three at Aberleigh are employed for a total of 85 hours a week. There are two qualified DT's and one qualified caregiver that are assigned to the rest home and hospital and secure units. On the day of audit Aberleigh's DT team leader was not on duty and therefore unable to be interviewed. The DTs oversee the activities in the psychogeriatric unit where the caregivers integrate activities into the daily activities for the small number of residents. The DT leader will review resident's recreational needs as the occupancy and need increases. Activities are provided seven days a week. The activity team are kept informed of resident's health, mobility and cognitive status by reading the handover sheets and accident/incident reports. The team meet with the RN weekly for a resident update.

The team meet monthly to plan the programme for the rest home and hospital and the two secure care units. Activities are provided by the team from 1.30pm to 4.30pm in the dementia "homes". Both "homes" combine for group activities as appropriate. One on one time is spent with residents in all units as per the activity care plans. The rest home and hospital programme is flexible to meet the needs of the residents and include (but not limited to); exercise, movements to music, word games, musical housie, old time stories, newspaper reading, crafts, baking, happy hours, Mrs Whippy visits, outdoor walks and pampering activities.

The dementia "home" programme is focused on household/meaningful tasks, reminiscing and sensory activities such as manicures and pampering activities, baking, garden walks, chats, music and sing-alongs, board games, café style afternoon teas, bowls and happy hours. Regular entertainment is scheduled. There are community volunteers who visit and share skills such as pottery, assist with resident shopping and other activities. RSA members visit regularly. Inter rest home activities and animal visits are enjoyed. There are fortnightly interdenominational church services and Sunday Catholic services/communion. Residents are supported to attend their own church. Ethnic and cultural preferences are met as evidenced in the activity care plans sampled. There are twice weekly van outings. The wheelchair taxi is used as

required.

The DT's have current first aid certificates. Activity assessments, activity plan, 24 hour MDT plan, progress notes and attendance charts are maintained. Resident meetings are held in the rest home, hospital and dementia units. The DT team meet regularly with the families and there is family involvement in the development and review of the care plans.

The DT team attend all relevant education offered on site and attend the regional company South Island DT training day which is held annually.

ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. The activity care plan and 24 hour MDT care plan is reviewed at least six monthly. Weekly progress notes are written into the integrated notes.

ARHSS 16.5g.iv: Caregivers are observed throughout various times through the day diverting residents from behaviours. The caregivers integrate activities into the resident activities of daily living. The DT oversees activities and provides support for the caregivers.

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Nursing care plans are reviewed and evaluated three monthly by the MDT team for hospital and psychogeriatric residents and six monthly for rest home and dementia care residents. The MDT includes the nursing and care staff, DT, physio, resident/family/whanau/EPOA as appropriate. Other health professionals are involved as appropriate. Short-term care plans are reviewed as required and are resolved or if an ongoing problem added to the long term care plan. There is at least a three monthly

review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. There is evidence of on-going review and changes to care plans.

The three monthly written review covers resident recordings (weight, blood pressure, and pulse), physical examination, restraint (if applicable), behaviour, family discussions, medication review and falls (if relevant).

ARC & ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

D16.4a Care plans are evaluated at least six monthly more frequently when clinically indicated.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) specific medication devices (such as spacers, oxygen, IV therapy, sub-cut fluid administration, novo-pen, etc.) h) medication errors, i) emergency medications, j) staff training, k) storage and administration of controlled drugs, l) alternative medication and m) medication audit. There is one main locked medication room situated off the main nurse's station for the rest home and hospital area. There are plans for shelving and locked cupboards to be built in the medication room. The controlled drugs safe is bolted to a temporary shelving unit.

The service uses the robotics blister packs for regular medications and medico for PRN. The RN checks the regular blister pack medications and non-regular medications monthly on arrival from the supplying pharmacy. Medication reconciliation is implemented via the 'medication management on admission and transfer policy'. RN's only administer medications in the hospital and psychogeriatric units. Senior caregivers administer medications in the rest home and dementia care unit. Orientation to medications include a self-learning package and supervised medication rounds. Annual competency and medication education has been completed. Liverpool care pathway (LCP) is in place for end of life/palliative care. RN's have completed syringe driver education and refreshers.

Standing orders are not used. There is an emergency pharmacy stock of medications. The controlled drugs register evidences weekly controlled drug checks. Controlled drugs administered are signed by two medication competent persons. There is a six month pharmacy audit dated December 2013. All eye drops in use are dated on opening. The medication fridge is monitored daily.

The medication folder contains specimen signature list, signing sheets for nutritional supplements, alert labels for medications and duplicate name. There are no self-medicating residents in the rest home or hospital unit. There are no gaps in the signing sheets for regular or prn medications. This is an improvement since the previous audit. All prn medications are dated and timed. PRN medications prescribed have an indication for use.

The previous finding regarding medication documentation has been addressed and monitored.

Medication charts had current (dated) photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts.

D16.5.e.i.2; 12 medication charts reviewed identified that the GP had seen the reviewed the resident 3 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.

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

**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.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There is a Kitchen Service Manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. There is a cook on duty each day from 6.45am to 5.15pm to prepare, cook and serve the meals. A tea aide is on duty from 16.45pm to assist with the evening meal, supper and cleaning duties (including the mopping of floors). All staff have attended food safety and hygiene, chemical safety, first aid and relevant in-service offered on-site.</p> <p>The kitchen is located within the hospital/rest home end of the facility. There is a small dining area outside of the kitchen where mobile resident may dine if they wish. Containers of food are transported in hot boxes to the rest home/hospital and the dementia care kitchenettes where caregivers plate and serve the meals. Meals are plated and transported in hot box to the psychogeriatric unit dining room. Each unit has a folder accessible to the caregivers serving meals that details resident food</p>

dislikes/likes and special requirements.

There is a four weekly summer menu in place that has been reviewed by the company dietitian. All cooking and baking is done on site. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known and alternative foods are offered. Cultural and spiritual needs are met. Lip plates and specialised utensils are available as needed to promote independence at meal times. There are additional nutritional snacks available for residents including (but not limited to): sandwiches, jellies, instant puddings, fruit and biscuits. The cook receives a list of residents who require protein drinks. Protein drinks are made up daily and delivered to the kitchenettes. Each unit has a kitchenette with a microwave, dishwasher and fridge. There are adequate fluids sighted in the kitchenette fridges and protein drinks are available. All facility fridges have temperatures recorded daily. There is daily monitoring of hot food temperatures (end cooking and prior to delivery to the units), chiller, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. All perishable foods in the kitchen fridges and freezer are dated. The dry good store have all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook is observed wearing appropriate personal protective clothing. There are fly screens on the windows. Chemicals are stored safely within the kitchen. There are safety data sheets available.  
ARHSS D15.2f; E3.3f There is evidence that there is additional nutritious snacks available over 24 hours for the dementia and psychogeriatric residents.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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 1.4.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The facility displays a current building warrant of fitness which expires on 1-July-2014. The fire evacuation scheme for the new dementia and psychogeriatric units has yet

to be approved by the New Zealand Fire Service (refer 1.4.7). The current fire evacuation scheme was approved in May 2008 for the original buildings. The certificate for public use has been issued by the Marlborough District Council for the completed building work – dated 26 November 2013. The psychogeriatric unit is now secure with keypad entry locks having been installed. The outside areas of the new dementia unit and psychogeriatric unit have also been completed with new gardens, concrete paved walkways, rails and ramps, seating and shade provided. Each garden area attached to the units is safe and secure with fencing and locked gates. The service has made improvements in these areas from previous verification audit. The lounge areas in each unit area is designed so that space and seating arrangements provide for individual and group activities.

The following equipment is available: pressure relieving mattresses, shower chairs, sling and standing hoists, heel protectors, lifting aids. Interviews with four caregivers who work across all service levels, confirmed there was adequate equipment. There are quiet, low stimulus areas that provide privacy when required.

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

All buildings, plant, and equipment comply with legislation.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

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

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Previous verification audit finding (#1.4.3.1) around hot water temperatures not being monitored as some bathrooms facilities had not been completed in the new dementia and psychogeriatric units. All bathrooms are now complete. Monthly hot water temperatures are monitored and recorded (sighted) and evidence that resident areas (bathroom, hand basins, showers) are now within acceptable limits. Records from November and December 2013 were reviewed. All temperatures were within 41 and 45 degrees Celsius. This is an improvement from the previous audit.

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

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Previous verification audit identified that: a) the service did not have a new approved evacuation scheme for the completed building work.; and b) the call bell system was not yet fully installed and in working order in all areas. In relation to a), advised by the business project manager that this remains outstanding as they await the installation of one more fire door. This remains a required improvement. In relation to b), the call bell system has been fully installed and is in working order. The service has made improvements in this area.

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

Where required by legislation there is an approved evacuation plan.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The original buildings have a current approved fire evacuation scheme dated 16 May 2008
<b>Finding:</b> The business project manager advised that approval for the new fire evacuation scheme has been applied for with the New Zealand Fire Service (NZFS), however, the facility is waiting for the installation of one more fire door in order for approval to be granted.
<b>Corrective Action:</b> Provide evidence that the NZFS has approved the new fire evacuation scheme.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

#### Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

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

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

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### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has four residents assessed as requiring restraint (two dementia residents with lap belts and one psychogeriatric residents – one with a lap belt and one with hand holding). There are no residents at Aberleigh with enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. One acting clinical manager, three registered nurses and four caregivers are familiar with this. The restraint coordinator (clinical manager) was not on duty and was therefore unable to be interviewed, however, the acting clinical manager (also the education coordinator) was conversant with restraint minimisation and in managing challenging behaviours. A restraint register is maintained. Two residents with restraint (one dementia and one psychogeriatric) files were reviewed and evidenced that appropriate documentation is completed including assessments, planning, monitoring, consent and review of restraint.</p>

The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. Restraint/enabler use is discussed at quality meetings, at health and safety meetings and at registered nurse meetings. Restraint use audit last conducted December 2013. Staff received training around restraint minimisation and safe practice in July 2013 with 27 staff attending. Management of challenging behaviours education was provided in July, September, October and November 2013. Restraint questionnaires and competency are also completed for all care staff. There is a managing disturbed behaviour policy.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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 3.5: 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection,

treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality meetings, monthly registered nurse meetings and monthly infection control committee meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the operations manager, clinical manager and to organisational management. A registered nurse at Aberleigh is the designated infection control nurse.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

