

Summerset Care Limited - Summerset By The Park

Current Status: 28 January 2014

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

General overview

Summerset by the Park is currently certified to provide rest home and hospital level care for up to 65 residents (this includes rest home level care in 13 serviced apartments on level). On the day of the audit, there were 49 residents - 13 at rest home level care including one resident in a serviced apartment and 36 residents receiving hospital level care.

The village manager has significant experience in aged care and health management roles and has been in the position for three years. She is supported by an experienced nurse manager (RN). The facility is owned by the Summerset Group. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke positively about the care and support provided.

This audit identified improvements required in the following areas by the service; timeliness of long term care plans, clinical interventions and restraint monitoring.

This audit has also assessed a further 42 serviced apartments on level two of the facility as suitable for rest home level care residents.

Audit Summary as at 28 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

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

Consumer Rights as at 28 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 28 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 28 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 medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 28 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.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 28 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Infection Prevention and Control as at 28 January 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 28 January 2014

Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services is available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Care plans reflect the resident and family values as confirmed through interviews with residents and family.

There are policies around cultural sensitivity and appropriateness with links to a kaumatua when required and access to spiritual services.

Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised.

Residents and family interviewed praised the support and care provided.

Organisational Management

Summerset by the Park has a quality and risk management system that includes documented policies and procedures, review of incidents and complaints, satisfaction surveys, risk management and implementation of an internal audit schedule that includes documentation of corrective actions. The quality, management and resident/family meetings serve to communicate any quality improvements. There are meetings at all levels to discuss quality data and improvements including the following: health and safety meetings with a focus on falls, restraint, infection control; staff meetings; quality meetings; quarterly resident/family meetings; continuing care centre meetings for the registered nurses/enrolled nurses and caregivers (separate meetings); housekeeping and activity/nurse manager meetings.

New staff complete an orientation/induction programme and caregivers state that this includes a buddy system to ensure that they are supported into the position.

There is a documented and implemented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are rostered 24 hours a day with an on call system in place.

The service has recruited staff to meet occupancy and acuity requirements and this is per the staffing model documented in the policy. There is also a staffing document to manage the 42 serviced apartments verified at this audit, which are located on the second floor. This includes oversight of all clinical issues by the nurse manager and the clinical nurse leader and implementation of the one to ten ratio of staff to residents for rest home level care.

Continuum of Service Delivery

The service has assessment process and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. There are improvements required around pain management, weight loss management and care planning. There is a recreational therapist and programmes running that are meaningful and reflect ordinary patterns of life. There are also weekly outings into the community and significant input from community groups.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary.

Food services policies and procedures are appropriate to the service setting. The food service is contracted to Medirest. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report that individual preferences are well catered. Additional snacks are available if the kitchen is closed.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers.

Documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. Visual inspection evidences compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

Documented systems are in place for essential, emergency and security services. Staff interviews and review of files provides evidence of current training in relevant areas. Visual inspection evidences alternative energy and utility sources are maintained, an appropriate call bell system is available and security systems are in place.

The 42 serviced apartments on level two have been assessed as suitable to provide rest home level as part of this audit. All have call bells in each bedroom and the bathroom that connect to the central call bell system. All rooms have a lounge and there are a combination of one, two and three bedroom apartments. Bathrooms are large enough to cater for the needs of rest home level residents.

Restraint Minimisation and Safe Practice

There are documented policies and procedures around restraint use and use of enablers. Currently there are four residents using restraint (lap belts and bed rails) and one with an enabler.

Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

The use of restraint and enablers is discussed at the monthly quality meeting (meeting minutes sighted), the health and safety monthly meeting and the six monthly restraint approval group meeting.

Improvement is required to documentation of monitoring of use of restraint and enablers.

Infection Prevention and Control

There are infection control policies that are implemented with a registered nurse identified as the infection control coordinator. The nurse manager provides support from a clinical perspective. Infection control training is provided to staff at least annually and all staff have completed orientation and training around infection control since they started.

All infections are documented monthly in an infection control register. A monthly infection control report is completed.

The infection control coordinator has access to the nurse specialist at the District Health Board, general practitioners and other specialists as required.

The programme is approved and reviewed annually by the infection control coordinator through the quality and health and safety monthly meetings and through the infection control meeting six monthly.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Summerset Care Limited
Certificate name:	Summerset Care Limited - Summerset By The Park
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Summerset By The Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 January 2014 End date: 29 January 2014
Proposed changes to current services (if any):	
This audit has assessed 42 serviced apartments on the second level of the facility for use by rest home level residents.	

Total beds occupied across all premises included in the audit on the first day of the audit:	49
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Audit Team

Lead Auditor	XXXXX	Hours on site	14	Hours off site	6
Other Auditors	XXXXX	Total hours on site	14	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	28	Total audit hours off site	14	Total audit hours	42
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Number of residents interviewed	7	Number of staff interviewed	11	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	46	Number of relatives interviewed	9
Number of residents' records reviewed using tracer methodology	2			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	Not Applicable
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, 21 February 2014

Executive Summary of Audit

General Overview

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The village manager has significant experience in aged care and health management roles and has been in the position for three years. She is supported by an experienced nurse manager (RN). The facility is owned by the Summerset Group. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group.

Family and residents interviewed all spoke positively about the care and support provided.

This audit identified improvements required in the following areas by the service; timeliness of long term care plans, clinical interventions and restraint monitoring.

This audit has also assessed a further 42 serviced apartments on level two of the facility as suitable for rest home level care residents.

Outcome 1.1: Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services is available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Care plans reflect the resident and family values as confirmed through interviews with residents and family.

There are policies around cultural sensitivity and appropriateness with links to a kaumatua when required and access to spiritual services.

Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised.

Residents and family interviewed praised the support and care provided.

Outcome 1.2: Organisational Management

Summerset by the Park has a quality and risk management system that includes documented policies and procedures, review of incidents and complaints, satisfaction surveys, risk management and implementation of an internal audit schedule that includes documentation of corrective actions. The quality, management and resident/family meetings serve to communicate any quality improvements. There are meetings at all levels to discuss quality data and improvements including the following: health and safety meetings with a focus on falls, restraint, infection control; staff meetings; quality meetings; quarterly resident/family meetings; continuing care centre meetings for the registered nurses/enrolled nurses and caregivers (separate meetings); housekeeping and activity/nurse manager meetings.

New staff complete an orientation/induction programme and caregivers state that this includes a buddy system to ensure that they are

supported into the position.

There is a documented and implemented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are rostered 24 hours a day with an on call system in place.

The service has recruited staff to meet occupancy and acuity requirements and this is per the staffing model documented in the policy. There is also a staffing document to manage the 42 serviced apartments verified at this audit, which are located on the second floor. This includes oversight of all clinical issues by the nurse manager and the clinical nurse leader and implementation of the one to ten ratio of staff to residents for rest home level care.

Outcome 1.3: Continuum of Service Delivery

The service has assessment process and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. There are improvements required around pain management, weight loss management and care planning. There is a recreational therapist and programmes running that are meaningful and reflect ordinary patterns of life. There are also weekly outings into the community and significant input from community groups.

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Outcome 1.4: Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers.

Documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

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Outcome 2: Restraint Minimisation and Safe Practice

There are documented policies and procedures around restraint use and use of enablers. Currently there are four residents using restraint (lap belts and bed rails) and one with an enabler.

Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

The use of restraint and enablers is discussed at the monthly quality meeting (meeting minutes sighted), the health and safety monthly meeting and the six monthly restraint approval group meeting.

Improvements are required to documentation of monitoring of use of restraint and enablers.

Outcome 3: Infection Prevention and Control

There are infection control policies that are implemented with a registered nurse identified as the infection control coordinator. The nurse manager provides support from a clinical perspective. Infection control training is provided to staff at least annually and all staff have completed orientation and training around infection control since they started.

All infections are documented monthly in an infection control register. A monthly infection control report is completed.

The infection control coordinator has access to the nurse specialist at the District Health Board, general practitioners and other specialists as required.

The programme is approved and reviewed annually by the infection control coordinator through the quality and health and safety monthly meetings and through the infection control meeting six monthly.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	47	0	2	1	0	0
Criteria	0	98	0	2	1	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Two of seven resident files sampled (both hospital level residents) did not have a long term care plan completed within three weeks of admission.	Ensure all residents have a long term care plan completed within three weeks of admission.	180
HDS(C)S.2008	Standard 1.3.6:	Consumers receive	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Service Delivery/Interventions	adequate and appropriate services in order to meet their assessed needs and desired outcomes.				
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)Three of seven care plans do not include all interventions to guide staff. Examples include weekly weighs and the use of a pressure relieving cushion. One resident who the dietitian has instructed is to have weekly weighs is not having these. (ii) Two resident's files were sampled for residents who have on-going pain and both take PRN Oxynorm. Both have had a routine six monthly pain assessment but there is no on-going pain assessment documented. For one resident that giving of the Oxymora is documented in the progress notes but	(i)Ensure that care plans document all interventions to guide staff and that allied health professionals instructions are followed. (ii) Ensure on-going pain assessments occur for residents with on-going pain and that the effect of pain relief is documented.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				not the effect.		
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.3.4	<p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the 	PA Low	Monitoring forms are inconsistently documented with the restraint monitoring forms not always include evidence of checks completed.	Document monitoring of the use of restraint as per timeframes documented in the care plan and in the restraint assessment and review form.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		restraint.				

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: There is a code of rights policy. On interview all staff (five caregivers who work across rest home and hospital residents), one registered nurse, the clinical nurse leader and the nurse manager (registered nurse), are aware of resident rights and are able to describe how they incorporate consumer rights within their service delivery. Seven of seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) interviewed spoke highly of the staff respect of all aspects of the Code of Rights. Code of rights training is included in training (last provided in January 2013). Staff have all received an orientation to the service that has included training around Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility.

On entry to the service, residents receive an information pack that includes information around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and a service agreement. Large format and Maori information is also available and posters in English and Maori displayed.

Five caregivers who support rest home and hospital residents, the registered nurse, the clinical nurse leader and the nurse manager interviewed state that they take time to explain the rights to residents and their family members.

On entry to the service, the nurse manager or registered nurse discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy.

The service is able to provide information in different languages and/or in large print if requested.

Information is also given to next of kin or EPOA to read with the resident and discuss.

Seven of seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) are able to state their understanding of the code of rights particularly around privacy, respect, complaints.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, rights information, advocacy and Health and Disability Commission information.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a privacy and dignity policy.

Staff are observed respecting resident's privacy and can describe how they manage maintaining privacy and respect of personal property.

All seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) interviewed indicate that staff are highly respectful and maintained residents privacy especially when discussing personal issues and that personal belongings are not used as communal property.

Privacy training last occurred in February and November 2013.

D4.1a The resident's initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly as described by the five caregivers, registered nurse, clinical nurse leader and the nurse manager interviewed.

There is a cultural awareness policy. All seven residents (four rest home and three hospital) interviewed state their needs are met including one resident who identifies as Maori.

All seven resident files reviewed (three rest home and four hospital) have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed can confirm this.

There is a spirituality policy. There are various churches locally and residents are encouraged to attend these if possible and as per their choice.

There are two church services per week (Catholic and Anglican). Staff have had training around spirituality last in October 2013.

All residents and family members interviewed indicate that resident's spiritual needs are being met when required.

The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview, five caregivers described how they encourage residents to engage in activities in the facility and to link with community activities including church groups whenever possible

There is a preventing abuse and neglect policy and the topic is covered at orientation with this completed in the past year by all staff. Training was last provided to staff in August 2013. Staff interviewed are able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues.

Discussions with the village and nurse managers identified that there have been no episodes of abuse of neglect at the facility since it opened and there are no incidents of abuse documented in incident forms reviewed.

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 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

A3.2: The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e) and a Maori health policy. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policy and plan. The plan and policy have been developed by Summerset in consultation with Maori advisors. There are residents who identify as Maori. One resident has strong cultural needs and these are expressed in the care plan. Two others have varying cultural links and requirements and all identify family as being the most important. Summerset by the Park identifies cultural safety issues for Maori and can manage these on an individual basis as described by the registered nurse, clinical nurse leader and nurse manager and caregivers interviewed. There is one staff member who identifies as Maori and the resident advocate who lives in the village identifies as Maori and is able to provide the service with support when required.

D20.1i: The service is able to access Maori advisors and local iwi advocacy services as identified in the Maori health policy and plan. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the registered nurses with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual's service delivery. Policies for Maori emphasise the critical importance of family. Discussions with the five caregivers, registered nurse, clinical nurse leader and the nurse manager confirm that they are aware of the need to respond to cultural differences. On interview, all staff are able to identify how to obtain support so that they could respond appropriately. Cultural safety and Treaty of Waitangi training has been provided to staff as part of the orientation programme and in April, June, July 2013.

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

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

Attainment and Risk: FA

Evidence:

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

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

The organisation plans to ensure Māori receive services commensurate with their needs.

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

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

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

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

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

Attainment and Risk: FA

Evidence:

The service has a cultural awareness policy, which describes the cultural needs of residents. There is a Maori health plan and policy.

All seven residents (four rest home and three hospital) report that they are satisfied that their cultural and individual values were being met.

D3.1g: The service provides a culturally appropriate service by carrying out a cultural assessment on admission with family/whānau involvement when available. Family are involved in assessment and the care planning process as confirmed by family interviewed.

D4.1c: Care plans reviewed (seven including three rest home and four hospital) include the residents social, spiritual, cultural and recreational needs.

Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implemented within the service delivery.

There is one resident who identifies as Fijian Indian. The family is involved daily and there are cards with key phrases in the room for staff to refer to. There are also Fijian Indian staff who can communicate in the appropriate language.

There is a Chinese resident and family visit daily. The registered nurse and doctor communicate with the resident in the same language.

One resident who identifies as being from Sri Lanka also has family who visit daily.

Staff are able to communicate in Samoan, Fijian Indian, Japanese, Chinese, Tongan, and Filipino.

Staff describe one resident who was supported by the Samoan staff member during the dying process.

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

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

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

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

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: <p>The facility has a sexual behaviour policy which states there will be zero tolerance against any discrimination occurring. The abuse and neglect policy covers harassment and exploitation. All seven residents (four rest home and three hospital) report that staff show respect and there is no evidence of discrimination or coercion. Elderly abuse prevention training occurs at orientation and on a two yearly basis and includes professionalism and standards of conduct with all staff having had training around abuse and neglect as part of orientation in 2013 (orientation checklists documented in seven of seven staff files reviewed). Training around abuse and neglect has last been provided in August 2013. The nurse manager and registered nurses supervise staff to ensure professional practice is maintained in the service and both are able to describe their role in ensuring that professional boundaries are maintained. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>

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

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

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA
Evidence: <p>The service has policies to guide practice that align with the health and disability services standards. There is a quality and risk framework and programme that is being implemented that includes performance monitoring. The caregivers are expected to complete Career Force NZQA level two training as a minimum and an internal in-service training programme is implemented. Across Summerset, quality data benchmarking groups are established for facilities with similar service provision. Summerset by the Park is currently benchmarked with other Summerset facilities that provide rest home and hospital level care. Both the nurse manager and the village manager attend external training sessions appropriate for their positions. The service has made improvements since the previous audit and in response to issues identified through the complaints process. These include;</p> <ul style="list-style-type: none">a) Implemented strategies to improve the dining experience.b) Staff employed to meet occupancy and acuity rates with a review of staffing completed. This has included appointment of another recreation therapist (30 hours a week) and an extra registered nurse on the afternoon shift.c) Appointment of two enrolled nurses, one part time and one full time along with the appointment of a clinical nurse leader.d) Increased housekeeping staff.e) Extra equipment has been purchased relative to the increase in higher acuity hospital level residents. This has included extra air mattresses, sensor mats,

another sling hoist, portable bain-marie to ensure that meals are delivered not, a bigger toasting machine and a wheelchair weigh scale. The care centre ambience has been improved with the introduction of an upright aquarium, an upgraded family room and the placement of a vending machine for visitors, residents and staff for after-hours snacks.

f) Increased visibility of the nurse manager on the floor with all seven of seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) confirmed that they can go to the nurse manager to discuss issues and suggest improvements.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>There is an open disclosure policy, which describes ways that information is provided to residents and families.</p> <p>There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning and receive and provide on-going feedback.</p>

Regular contact is maintained with family including if an incident or care/ health issues arises.
 Family members interviewed state they are well informed and involved when needed in residents care.
 D16.4b: All seven of seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) interviewed confirm the admission process and agreements documentation were discussed with them.
 Residents and family state the service provides an environment that encourages open communication.
 The admission agreement covers all the areas for the services contractual requirements. All include signed admission agreements on the date of admission.
 Discussions with five caregivers identified their knowledge around open disclosure and reporting to registered nurses who in turn contacts family.
 Seventeen of 17 incident/accident forms reviewed identify that the next of kin is contacted.
 There are resident meetings quarterly with the last being in December 2013. There is a named resident advocate who facilitates the meeting and the newly appointed secretary (resident) interviewed confirms how the meetings have changed to ensure that any feedback is addressed.
 Annual resident and relative surveys are also completed – last completed in October (collated in December 2013). Residents and relatives in the 2013 survey are satisfied with the service.
 Staff wear name badges and there is a notice board in the continuing care centre with photos of staff.
 The service has policies and procedures available for access to District Health Board interpreting services and residents (and family) are provided with this information in resident information packs.
 There are three residents with English as a second language (Fijian/Indian, Chinese and Sri Lankan). All have phrases and key words written in the room by family and staff so that staff can communicate easily. Family for all three are in daily and are used to interpret specific information. Communication needs and strategies are documented in care plans (sighted in one care plan specifically reviewed around communication).
 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 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 agreement.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Informed consent policies include; informed consent and associated form and a refusal of treatment form, The informed consent form includes medical, listen up (no lifting), transport, purchases and charges. Informed consent information is included in the information pack for new residents. The consent policy includes clear instructions for providing information to residents during the admission process. The clinical nurse leader discussed informed consent processes with residents and their families during the admission process. Nine of nine relatives (four from the rest home and five from the hospital) confirmed that informed consent had been discussed with them. Consent is gained for procedures outside of normal care. Examples sighted in resident files include consent to have a catheter changed (one file) and consent for wounds to be photographed (two files). There is an advanced directive policy, a not for resuscitation policy and a not for resuscitation authorisation by competent resident form, a not for resuscitation authorisation for incompetent resident form and a resuscitation authorisation form. Completed resuscitation treatment plans and resuscitation advance directive forms were completed on seven of seven files (three from the rest home including one from a serviced apartment and four from the hospital) and</p>

they were appropriate and are documented as reviewed by the GP three monthly.
 The nurse manager, clinical nurse leader and registered nurses are responsible for ensuring consent is gained on admission (or close to).
 Discussions with five caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with the nurse manager, the clinical nurse leader and one registered nurse identified that they are familiar with advanced directives and the fact that only the resident (deemed competent) can sign the advance directive.
 D13.1 There were seven admission agreements sighted and all had been signed on the day of admission
 D3.1.d Discussion with nine of nine relatives (four from the rest home and five from the hospital) identified that the service actively involves them in decisions that affect their relatives lives.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an advocacy policy. Staff last received training on advocacy services and the role of the enduring power of attorney as part of the orientation programme and in January 2013.
Information about accessing advocacy services is available in the service including on the notice board in the continuing care centre. This includes advocacy contact details.
The information pack provided to residents at the time of entry to the service provides residents and family with advocacy information.
There is a residents meeting facilitated by an external resident advocate. The secretary (interviewed) who is a resident in the apartment takes meeting minutes (viewed) and communicates with the village manager regarding issues raised.

Advocate support is available if requested. Interview with five caregivers, seven of seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) confirms that they are aware of advocacy and how to access an advocate.
 D4.1d; Discussion with seven family identified that the service provides opportunities for the family/EPOA to be involved in decisions.
 D4.1e: The resident file includes information on resident's family/whānau and chosen social networks.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff state that residents are encouraged to build and maintain relationships. On interview, all residents and family members confirmed this. D3.1h: Discussion with nine of nine family members (four rest home and five hospital) confirm that they are encouraged to be involved with the service and care. D3.1.e: Discussion with staff, residents and family members confirmed that residents are supported and encouraged to remain involved in the community noting that there are few currently who do this. Examples given of residents attending activities in community include one who goes home to have lunch with family. The activities include the RSA who visit

the village with residents from the continuing care centre visiting, competitions with other facilities including bowling and quizzes and visits from local schools. Because of an incident around a theft of money in the continuing care centre, the police now visit weekly and actively get involved in the bowls programme. Visitors are encouraged to attend and were seen visiting the service on the days of the audit. Nine of nine family members (four rest home and five hospital) interviewed confirm that they can visit at any time. The village manager confirms that family can be accommodated when the resident declines. This is made available in the rooms or in other areas of the service if there is full occupancy.

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

Consumers have access to visitors of their choice.

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

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

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Information around complaints is provided on admission. Interviews with seven of seven residents (four rest home and three hospital) and nine of nine family members (four rest home and five hospital) confirms an understanding of the complaints process.

All staff interviewed including five caregivers, registered nurse, clinical nurse leader and the nurse manager are able to describe the process around reporting complaints

There is a complaints register. The 2013 complains reviewed show that there is response to the complaint in a timely manner. Verbal and written complaints are documented as stated by the village manager.

Complainants are provided with information on how to access advocacy and Health And Disability Commissioner if resolution is not to their satisfaction and the village manager sends the leaflet as well in the response pack.

Discussions with seven residents and nine family members confirm that any issues are addressed and they feel comfortable to bring up any concerns.

Three complaints identified as being lodged with the District Health Board have been addressed. Issues from each tracked on the day of the audit confirm that all issues have been explored with corrective actions put in place and evidence of improvements made documented.

The village manager confirms that there are no complaints lodged in the last year with the Health and Disability Commissioner.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Summerset by the Park provides rest home and hospital level care for up to 52 residents - all are swing beds plus rest home level care in a total of 55 serviced apartments (13 currently certified and 42 additional serviced apartments assessed as suitable on the day of the audit).
On the day of the audit, there are 49 residents - 13 rest home including one resident in a serviced apartment and 36 hospital level care.
There is a retirement village attached as part of the complex with overall management of the site provided by a village manager.
The philosophy, vision and values is documented as part of the quality plan and included in the admission pack.
There is a Summerset business plan 2014, 2014 health and safety plan and an organisational quality and risk improvement plan 2014. All are individualised to Summerset by the Park. The 2013 plans sighted include review with any on-going goals put into the 2014 plans.
The service is managed by the village manager who has worked in aged care for 10 years, is a registered nurse (not with a current annual practicing certificate) and has experience as a medical sales representative. The village manager has completed an orientation with Summerset which includes employment and administration, specific policies to read and sign, meeting schedule, tour of site, customer service, communicating with staff, contracts and auditing, health and safety, HR, emergencies, finance, primary care, intranet use, IT protocols, key staff members, resident care and services, sales and marketing, visiting another Summerset site performance management, property and maintenance, quality and the Summerset way (philosophy).
A nurse manager is employed to oversee the clinical running of the rest home and hospital. The nurse manager is supported by an organisation clinical and quality manager and clinical education manager. The nurse manager has been in the role for six months and has previous clinical and management experience in aged care for over six years in a large aged care facility.
Summerset provides a comprehensive orientation and training/support programme for their managers.
Village managers have monthly teleconference meetings with head office operations staff.
The nurse manager is mentored and supported by the clinical and quality manager.
ARC, D17.3di (rest home), D17.4b (hospital): The village manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: During the temporary absence of the manager, the nurse manager undertakes the role of village manager. The nurse manager has a background of six years in aged care including rest home and hospital level care. D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies,

quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.
The nurse manager is able to describe the role around acting manager.

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

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

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

Attainment and Risk: FA
Evidence: D5.4 The service has up to date policies/ procedures to support service delivery. New or revised policies are available for care staff to read and sign that they have read and understand the changes (policy release folder). Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility. There is a document control programme with reviews dated and documented. There is an organisational quality and risk improvement plan that is documented in 2014 to include quality objectives relative to Summerset by the Park. The quality programme is reviewed annually (2013 review sighted) and is being implemented. Information is reported through the monthly meeting (minutes sighted and documented since July 2013) and staff meetings with data documented.

The monthly quality meeting discusses key components of the quality programme and standing agenda items of the programme include internal audits, infection, restraint, incidents, complaints and health and safety. Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. The clinical and quality manager analyses all infection control statistics and incidents and accidents monthly with a graph produced that enables the service to benchmark data against similar services. There are meetings at all levels to discuss quality data and improvements including the following: monthly health and safety meetings with a focus on falls, restraint, infection control; monthly staff meetings; monthly quality meetings; quarterly resident/family meetings; monthly continuing care centre meetings for the registered nurses/enrolled nurses and caregivers (separate meetings); monthly housekeeping; weekly activity/nurse manager meetings. While infection control is discussed at all meetings and particularly in the quality and health and safety meetings, there is also a six monthly infection control meeting (which includes annual review). There is a six monthly restraint meeting, which is identified as the approvals group. Reports are documented that include the nurse manager report to the clinical and quality manager and the clinical education manager and the village manager report, which is sent to the operations manager. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is reviewed annually. Summerset has a data tool "Sway- The Summerset Way" that was launched in 2012 by the organisation. Sway is integrated and accommodates the data entered. The internal audit schedule is implemented since July 2013. Corrective actions are documented with evidence of resolution of issues as these are identified. D19.3: There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as use of sensor mats and landing mats, hi/lo beds and ultra-low beds, falls risk assessments conducted, physiotherapy input, and exercise programme twice a week with recreation therapists and increased supervision of residents with frequent falls). Annual surveys are conducted of residents and relatives – last completed in October 2013 with results communicated in December 2013 (overall satisfaction of 84%). There is an annual food satisfaction survey completed last in November 2013. There is a staff satisfaction survey completed annually with the overall satisfaction from the June/July 2013 survey being 91.2%. All residents and relatives interviewed state they are regularly asked for feedback regarding the service and all praised the service for support provided.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information.</p> <p>The reporting system is integrated into the quality risk management system.</p> <p>Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the nurse manager who monitor issues. If risks are identified these may also be processed as hazards.</p> <p>Incidents are discussed at all meetings including quality, health and safety and staff meetings monthly and discussed at the clinical quality meetings at head office monthly.</p> <p>The clinical and quality manager analyses all infection control statistics and incidents and accidents are graphed monthly with discussion at the quality</p>

meeting.

Discussion with the village manager indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.

All 17 incident forms reviewed included appropriate clinical follow up by the nurse manager.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are comprehensive human resources policies as part of the policy manual, this includes job descriptions. There are employment guidelines and templates, which include application form, interview questionnaire, reference check forms and standard letter for employment. Recruitment and employment is completed by the village manager for the junior staff and by the nurse manager for the registered nurse roles with support from the village manager. Any senior roles are recruited by the operations manager, the village manager and a member of the head office.

The service has recruited staff to meet occupancy and acuity requirements and this is per the staffing model documented in the policy.

Seven of seven staff files reviewed indicate that all have a documented contract signed by the employee and employer, orientation, application, police check, training records, a current annual practicing certificate if required and referee checks. Annual practicing certificates are documented and filed for doctors, pharmacists, podiatrist, dietitian and other health professionals working in the service.

There is a training policy for staff that includes the provision of compulsory subjects and a training programme will be implemented. The 2013 training programme sighted includes key aspects of the health and disability standards and has been well implemented. There is a 2014 training plan documented. Orientation of caregivers includes completion of stage one Careerforce and all who have not got this already are expected to start this as soon as they have completed orientation with the intention that they complete this within six months.

Staff interviewed including five caregivers are able to describe their roles as per their job description.

There is also a staffing document to manage the 42 serviced apartments verified at this audit, which are located on the second floor. This includes oversight of all clinical issues by the nurse manager and the clinical nurse leader and implementation of the one to ten ratio of staff to residents for rest home level care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery.

Care staff including the registered nurse, nurse manager, village manager, five caregivers and the village manager report state that staffing levels and the skill mix is appropriate and safe for hospital and rest home level care. All nine of nine family members (four rest home and five hospital) and seven of seven residents advise that they felt there is sufficient staffing.

The service has a staffing levels policy implemented, which determines that there are registered nurses on duty at all times, and that at least one staff member on duty will hold a current first aid qualification – roster reviewed indicates that this occurs. The staffing policy includes two registered nurses on site on the morning and afternoon shifts (with the nurse manager – registered nurse also on the AM shift). There is implementation of a one caregiver to five hospital residents and one caregiver to 10 hospital residents noting that levels are adjusted along with acuity. The nurse manager advises that the roster is able to be changed in response to resident acuity and the spreadsheet to accommodate this is documented.

New staff are rostered on duty with an experienced staff member during the orientation phase of their employment.

Medirest provides staff for food services as part of their contract.

The service employs 46 staff including the following: cleaners (seven days a week), recreational staff (60 hours per week), administration staff (40 hours per week), caregivers, eight registered nurses, one village manager, one clinical nurse leader and one nurse manager.

Morning shift includes eight caregivers including four short shift; afternoon shift – eight caregivers including three short shift; night duty - two caregivers.

Staffing issues raised in the complaints received by the organisation have been addressed with the following implemented since July 2013: two enrolled nurses (new positions) commencing in February 2014, an extra one fulltime recreation therapist appointed and operational since January 2014 (extra 30 hours a week), an extra 38 hours a fortnight housekeeping commencing in February 2014, additional eight hours housekeeping overnight with cover also for the serviced apartments with any rest home residents in them. A caregiver to support serviced apartments that include any rest home residents (one currently) is designated now on the AM and PM shift. The physiotherapy hours have increased from two to three hours a week.

Advised that once the 42 serviced apartments on level two commence having rest home level residents, clinical oversight will be provided by the existing clinical nurse leader, nurse manager and registered nurses. Caregivers will be employed on at least a one to ten ratio with the first caregivers commencing with 24 hour cover when the first rest home level resident takes residence and the second commencing when the 11th resident takes residence etc. Staffing can be increased according to acuity as confirmed by the nurse manager.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate). All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident's files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home and hospital setting. The service keeps a resident register. Summerset by the Park has a policy and process that describes the control of documents and records that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses' station in a secured room. Old files are individually archived and locked in a secure area for 10 years Resident records are up to date and reflect residents' current overall health and care status. Records can be accessed only by relevant personnel. Care</p>

plans and progress notes are legible, signed and dated.

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

On admission to services there is an assessment of residents and this was evidenced in seven of seven files (three from the rest home including one from a serviced apartment and four from the hospital) reviewed .

Seven of seven residents (four from the rest home and three from the hospital) and nine of nine relatives (four from the rest home and five from the hospital) all stated that they kept informed on admission.

There is a well-developed information pack, which included advocacy, health and disability information, fees - where applicable, recreation services, menus and services available.

There is a care facility - resident admission and orientation policy and procedure

The service has a comprehensive admission policy including that information gathered at admission is retained in resident's records.

Seven of seven residents (four from the rest home and three from the hospital) state they were given an information pack when viewing the facility and were able to discuss the admission process with the nurse manager and registered nurses.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

ARHSS D4.2

Attainment and Risk: FA
Evidence: The reason for declining service entry to residents is recorded and advised should this occur it is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

D16.2, 3, 4: The clinical nurse leader or registered nurses undertake the assessments on admission. The initial support plan is completed within 24 hrs. of admission in seven of seven files sampled (three from the rest home and four from the hospital). There is documented evidence that the care plans were reviewed by the clinical nurse leader or registered nurses and amended when current health changes. Of seven care plans sampled all have a documented care plan evaluation completed six monthly. Within three weeks, the long term care plan is completed by the clinical nurse leader or registered nurses as sighted in the five of the seven files sampled (three from the rest home and two from the hospital). This is an area requiring improvement. Activity assessments and activities care plans were completed by the recreation therapist in all files reviewed.

D17.1 (b) Copies of the registered nurses, GPs and other allied health providers practising certificates are copied and kept on file by the management team.

D16.5e: All seven resident files reviewed identified that the general practitioner had seen the resident within two working days. It was noted in the five of the seven resident files reviewed that the general practitioner has assessed the resident as stable and is to be seen three monthly that these reviews have occurred alongside as needed reviews. The other two residents are seen monthly by the GP.

Five caregivers (who worked across all shifts) and the clinical nurse leader and the registered nurse interviewed describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed a handover was also witnessed.

Progress notes are written every shift by caregivers or more often if there are any changes. RNs also write concerns in the medical notes.

All seven resident files identify integration of allied health personnel and a team approach is evident.

Tracer Methodology rest home:

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

Tracer methodology hospital:

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: PA Low
Evidence: The initial support plan is completed within 24 hrs. Of admission in seven of seven files sampled (three from the rest home and four from the hospital). There is documented evidence that the care plans were reviewed by the clinical nurse leader or registered nurses and amended when current health changes. Of seven care plans sampled all have a documented care plan evaluation completed six monthly. Within three weeks, the long term care plan is completed by the clinical nurse leader or registered nurses as sighted in the five of the seven files sampled (three from the rest home and two from the hospital).
Finding: Two of seven resident files sampled (both hospital level residents) did not have a long term care plan completed within three weeks of admission.
Corrective Action: Ensure all residents have a long term care plan completed within three weeks of admission.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The initial support plan is developed with information from the initial assessment. Clinical risk assessments including continence, safe handling, falls risk, pressure area risk, culture and a pain assessment are completed following admission and reviewed at least six monthly in all seven resident files sampled. A MUST nutrition assessment is completed monthly for each resident.</p> <p>Risk assessment tools are used to effectively assess level of risk and required support for residents including (link 1.3.6.1). Two of seven files sampled are for residents who present behaviours that challenge. These files contain a behaviour assessment and related plan.</p> <p>Additional assessments were noted such as the Bristol stool chart and cultural assessments. Continuing needs/risk assessments are carried out by registered nurses.</p> <p>Needs outcomes and goals of consumers are identified and these link to care plans including falls assessments, continence care and diet (link 1.3.6.1). Seven of seven files sampled (three from the rest home and four from the hospital) contain all relevant assessments and these are current. Seven of seven residents (four from the rest home and three from the hospital) and nine of nine relatives (four from the rest home and five from the hospital) interviewed report having been involved in the assessment process.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Seven care plans were reviewed for this audit, four hospital and three rest home. Assessment tools relevant to a specific area of the support plan are completed (link 1.3.6.1). Residents' files include; daily progress notes, recordings - bowel and fluid charts, family contact record, short term care plans/wounds, long term care plans, risk assessments/nutrition, restraint/enabler documentation, care plan evaluations (MDT review), GP initial assessment and visits, lab results, allied health reports/progress notes, activities, consents and advance directives, letters, referrals and archived notes. Service delivery plans (lifestyle care plans) demonstrate service integration and demonstrate input from allied health including physio, speech therapist, GPs and podiatrist in files sampled. Link 1.3.6.1 regarding dietitian instruction not being documented in the care plan for one resident. Notes are maintained by the general practitioner and allied health professionals and significant events, communication with families and notes (as required) are maintained by registered nurses. Care plans are comprehensive and well written in four of seven files sampled. D16.3k: Short term care plans are in use for changes in health status. D16.3f Seven of seven files sampled (three from the rest home and four from the hospital) reviewed identified that family were involved.

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Summerset by the Park provides services for residents requiring rest home and hospital level of care. Overall, the lifestyle care plans are completed comprehensively. The care being provided is consistent with the needs of residents in most areas, this is evidenced by discussions with the five caregivers, nine of nine relatives (four from the rest home and five from the hospital), the clinical nurse leader, the nurse manager, one registered nurse and the village manager. There is a short-term care plan that is used for acute or short-term changes in health status.

Seven resident's files were sampled (three from the rest home and four from the hospital). All seven residents had ADLs and mobility well documented. The progress notes all document that the RN has reviewed progress notes weekly and followed up any outstanding problems identified.

Turning charts and fluid balance charts were sighted for four residents. All were completed accurately and show appropriate care being provided.

Two files were sampled of residents who have experienced weight loss (one from the hospital and one from the rest home). Both have had regular input from the dietitian and the kitchen manager is aware of the dietary needs of both residents. Both residents have been identified by the dietitian as requiring weekly weighs and supplements. Both have the use of supplements included in the care plan but neither have the need for weekly weighs documented in the care plan. For one of the residents the weekly weigh is occurring and for the other it is not. These are areas requiring improvement. In-service education around food and fluid management occurred in December 2013. The service has identified that a number of residents have experienced weight loss and have initiated a number of improvements to attempt to address this. These include developing a hard copy data base of resident's weights so the nurse manager can closely monitor weights and improving the dining experience to encourage residents to enjoy eating. This has been achieved by dividing the dining room into two areas and placing table clothes on all tables. The nurse manager (or the clinical nurse leader on his days off) attends the dining room every lunch time to address issues, ensure residents are being appropriately fed and that the right equipment is available for each resident. A feedback folder has been placed in the dining room so that residents are encouraged to feedback about meals. This is checked daily by the kitchen manager and nurse manager. A hot box has also been purchased so that meals can be kept hot for residents being served in their rooms. Across the care centre the overall weight trend for residents shows improvement

Two resident's files were sampled for residents who have on-going pain and both take PRN Oxynorm. Both care plans clearly document pain management techniques including both pharmacological and non pharmacological interventions. Both have had a routine six monthly pain assessment but there is no on-going pain assessment documented. For one resident the registered nurse progress notes document the effect of the Oxynorm each time it is administered. For the other resident that giving of the Oxynorm is documented in the progress notes but not the effect. These are areas requiring improvement.

Four resident's files were sampled for residents at risk of pressure areas. One resident with a current pressure area has a well-documented short term care plan that includes all appropriate interventions including regular skin checks and moisturising, two hourly turns and the use of a pressure relieving mattress. All four residents use pressure relieving mattresses and two hourly turning charts indicate these occur for all four residents. One resident has a special

pressure relieving mattress for her wheelchair and this is not included in the care plan. This is an area requiring improvement. Staff training around pressure area risk management occurred in October 2013 and January 2014.

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.

There are 10 residents with wounds including two pressure areas. All of these have an associated short term care plan. There are comprehensive wound assessments and plans for all wounds and all have been regularly reviewed.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

The GP interviewed reports confidence with the service. He is available during working hours and outside of working hours as confirmed by the GP and the clinical nurse leader.

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

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

Attainment and Risk: PA Moderate

Evidence:

Summerset by the Park provides services for residents requiring rest home and hospital level of care. Overall, the lifestyle care plans are completed comprehensively. The care being provided is consistent with the needs of residents in most areas, this is evidenced by discussions with the five caregivers, nine of nine relatives (four from the rest home and five from the hospital), the clinical nurse leader, the nurse manager, one registered nurse and the village manager. There is a short-term care plan that is used for acute or short-term changes in health status.

Seven resident's files were sampled (three from the rest home and four from the hospital). All seven residents had ADLs and mobility well documented. The progress notes all document that the RN has reviewed progress notes weekly and followed up any outstanding problems identified.

Turning charts and fluid balance charts were sighted for four residents. All were completed accurately and show appropriate care being provided.

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.

There are 10 residents with wounds including two pressure areas. All of these have an associated short term care plan. There are comprehensive wound

assessments and plans for all wounds and all have been regularly reviewed.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

The GP interviewed reports confidence with the service. He is available during working hours and outside of working hours as confirmed by the GP and the clinical nurse leader.

Finding:

(i) Three of seven care plans do not include all interventions to guide staff. Examples include weekly weighs and the use of a pressure relieving cushion. One resident who the dietitian has instructed is to have weekly weighs is not having these. (ii) Two resident's files were sampled for residents who have on-going pain and both take PRN Oxynorm. Both have had a routine six monthly pain assessment but there is no on-going pain assessment documented. For one resident that giving of the Oxynorm is documented in the progress notes but not the effect.

Corrective Action:

(i) Ensure that care plans document all interventions to guide staff and that allied health professionals instructions are followed. (ii) Ensure on-going pain assessments occur for residents with on-going pain and that the effect of pain relief is documented.

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 recreational therapist works Monday to Friday for a total of 30 hours each week. She is completing diversional therapy training. A second recreational therapist is currently undergoing orientation and will also work 30 hours per week meaning activities will be provided seven days per week. The activities programme is developed by the recreational therapist and each resident receives a copy of the monthly plan. The plan is easy to read and colourful, it can be printed in large type to assist those residents with who are visually impaired.

Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in indoor bowls, and an exercise programme. There is also reminiscing, crafts, music, art, entertainment, themed activities and a variety of activities to maintain strength and interests.

There are regular visits both from and to local schools and an after school care group visits weekly for the children to read to residents. There are regular quizzes and bowls competitions with other rest homes and weekly outings to local attractions. A group of local police compete with the residents for bowls and also attend the weekly happy hour to mix and mingle with residents.

D16.5d Monthly progress notes are written and six monthly evaluation is documented as occurring in this timeframe in the seven resident files reviewed. A diversional therapy assessment documents a social history and previous interests.

Seven of seven files sampled (three from the rest home and four from the hospital) have a documented activities plan.

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: There is evidence of resident and family (where appropriate) involvement in the review of support plans. D16.4a Seven of seven care plans sampled have a documented six monthly care plan evaluation. Four of seven files sampled (two from the rest home and two from the hospital) indicate that the care plan has been updated when needs change (see CAR 1.3.6.1). There are short term care plans to focus on acute and short-term issues. These are reviewed daily by a registered nurse until the issue is resolved or transferred to the long term care plan. ARC D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with the clinical nurse leader identified that the service has access to (but not limited to); speech language therapist, physiotherapist, diabetic nurse, wound care nurse, needs assessment, and geriatrician and this was evidenced in seven files reviewed. Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

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

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

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. The service uses the yellow envelope system. The files of two residents who had recently been transferred to hospital were sampled. The nurse manager and clinical nurse leader both report that yellow envelopes were completed and sent with the resident. However, for both residents a new yellow envelope was sent back to the facility with discharge information by the hospital so the initial yellow envelope was not available. Both files clearly document in the progress notes the time the resident was admitted to hospital and the reason why, and that family were informed. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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 service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011.

The facility uses two weekly supplied sachet medication packs. Medications are checked on arrival at the facility.

All medications are kept in two locked trolleys in the treatment room. The medication fridge temperature is recorded daily.

Fourteen resident medication charts were reviewed and all are identified with photographs and were current. There is no evidence of transcribing and all 14 medication charts sighted have been signed. On 14 of 14 medication administration records, all regular medications are signed as administered.

Three monthly medication review for the 14 residents was documented on the prescription chart.

There is a list of staff with specimen signatures that have been assessed as being competent to administer medications.

Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people and weekly stocktakes occur.

The service has implemented a new system around the management of anticoagulant therapy. The system involves the GP ordering and receiving INR blood tests/results and a copy of results is sent to facility. The GP faxes a prescription to the pharmacy (copy faxed to facility). The pharmacy dispenses into robotic pack and generates a signing sheet. This is delivered to the Summerset by the Park. The GP orders follow-up INR.

The nurse manager was able to demonstrate the same with clinical records / medication files of two residents on anticoagulant therapy.

There is a list of staff with specimen signatures that have been assessed as being competent to administer medications.

All staff that administer medication are competent and have received medication management training. The clinical nurse leader and registered nurse interviewed were conversant with the service medicine management policies procedures.

There is a self-medicating resident's policy available to guide staff practice if required. There are currently three residents self-administering medicines.

Medication audits occur annually. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Medication and any changes are discussed with the resident or family/whanau where appropriate and documented in the progress notes. This was verified in resident and family interviews.

All medication in the fridges, drug trolleys and cupboard were sighted.

D16.5.e.i.2; Fourteen 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a large kitchen and all food is cooked on site by Medirest contractors. D19.2: All staff working in the kitchen have food handling certificates and receive on-going monthly training from Compass.

On admission, the registered nurse completes a dietary profile and communicates individual resident's needs to the kitchen staff. This information is updated as required. Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process.

There is a daily cleaning schedule in place.

There is a comprehensive kitchen manual in place. The menu has been reviewed by a dietitian.

Audit of the main kitchen noted that fridge and freezer temperatures are monitored twice daily and are within acceptable limits.

This audit noted that all food in the fridge and pantry is dated and labelled. Meat was noted to be stored correctly and the kitchen was very clean.

Residents with special dietary needs have these needs assessed as part of the care planning process. The seven care plans reviewed all had eating and drinking assessed as part of the health needs assessment tool, and care plans reflected any special needs.

There have been a number of improvements to the food service (see 1.3.6).

Seven of seven residents (four from the rest home and three from the hospital and nine of nine relatives (four from the rest home and five from the hospital) report that meals have improved. All report that some meals are exceptionally good and others remain variable.

There is a kitchen manual.

The kitchen is well able to cater for the extra residents at rest home level care being approved in this audit. The kitchen manager reports that many of the residents in the 42 apartments already receive meals from the kitchen. The recently purchased hot box will keep meals warm as they are transported to residents on the third floor apartments.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (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

Attainment and Risk: FA

Evidence:

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

A visual inspection of the facility evidences the provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. These products were seen in sluice rooms and the laundry, gloves are in every ensuite and there are plentiful supplies of gowns on caregiver's trolleys. The service now has a standing order for PPE to ensure it never runs out. Clothing is provided and used by staff. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

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

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

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

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

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

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

Attainment and Risk: FA

Evidence:

The Sway electronic database provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and were reviewed using the Sway programme. Medical equipment was calibrated in January 2014. Hot water temperatures are monitored three monthly and this is documented in Sway. There is a current Building Warrant of Fitness that expires on 17 April 2014. Electrical testing and tagging is current and was last completed in August 2013.

A visual Inspection of the facility provides evidence of safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways etc.; transitions between surfaces or coverings are without abrupt change in level or gradient; and floor surface changes are identifiable by the consumer. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.

The village manager, clinical nurse leader, nurse manager, one registered nurse and five of five caregivers interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment. All caregivers wear a lifting belt at all times and the clinical nurse leader and register nurse report there are lifting belts available for them to use. The service has recently purchased a new hoist and there are now two sling hoists and two standing hoists. There is also chair scales and seated scales.

Family and residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Family and residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

ARC D15.3: The following equipment is available: electric beds, shower chairs, hoists and lifting aids.

The 42 serviced apartments being approved for rest home level care include 22 one bedroom apartments, seven two bedroom apartments and two three bedroom apartments. Each is approved for up to one rest home level resident. All rooms are large and one a single floor with large communal areas. There is a call bell in each bedroom and bathroom.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: <p>Visual inspection evidences toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>All bedrooms have ensuites (or bathrooms in the serviced apartments) and there are adequate number of toilets and showers to cater to all residents. There is also a communal toilet and shower. The toilets have appropriate access for residents based on their needs and abilities and facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. This includes the bathrooms in the 42 serviced apartments being approved for rest home level care. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately, secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Seven of seven residents (four from the rest home and three from the hospital) and nine of nine relatives (four from the rest home and five from the hospital) interviewed report that there are sufficient toilets and showers.</p>

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

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

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA
Evidence: Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff, residents and family. The bedrooms in the 42 serviced apartments being approved for rest home level care are large enough to cater for rest home level residents.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: Visual inspection evidences adequate access is provided to lounge, dining and other communal areas and that residents are able to move freely within these areas. Family and residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and the resident does not want to participate in them. There is a communal lounge in the second floor serviced apartment area being approved for rest home level care and all apartments have a lounge.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA
Evidence: <p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry is well managed and dirty to clean flow is evident. All laundry and cleaning is completed onsite by staff employed specifically to complete these tasks. There are covered linen trolleys used by the caregivers. The resident annual satisfaction survey includes laundry services and the service is audited annually. Laundry and cleaning are a seven day service. Residents and family interviewed report satisfaction with the cleaning and laundry service. A recent improvement around cleaning is a number of hand held vacuum cleaners have been purchased and are situated throughout the facility so caregivers can ensure all areas are clean before they move to a new area. Cleaning and laundry audits have been completed monthly with on-going improvements being made as a result of the audits. The 42 apartments being approved for potential rest home use during this audit are already cleaned by the service and laundry is completed for most residents. The same cleaning process will continue and the caregiving staff will be able to send laundry of rest home residents to the facility laundry which is able to manage the extra capacity.</p>

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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

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

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

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

Attainment and Risk: FA

Evidence:

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors. The service has a relationship with the local police who visit the service weekly to mix and mingle with residents during the happy hour.

Letters from New Zealand Fire Service reviewed dated June 2009 advising approval of fire evacuation schemes. The last trial evacuation was held in October 2013. As the 42 apartments being approved for use by rest home level residents are part of the existing building, they are included in the current approved evacuation plan and those residents have been included in all trial evacuations.

Staff interviews and review of files provides evidence of current training in relevant areas. All staff have current first aid certificates as confirmed in staff interviews and in staff files sampled. Emergency and security situation education is provided to service providers during their orientation phase and at appropriate intervals. This includes fire safety training and emergency security situations. Staff records sampled evidences current training regarding fire, emergency and security education. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; A visual inspection of the facility evidences: emergency lighting, torches, extra food supplies, emergency water supply, blankets, and cell phones. There is a gas barbeque should the mains gas supply fail. An appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, ablution areas, ensuite toilet/showers, the lounge and dining room.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

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

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

Where required by legislation there is an approved evacuation plan.

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

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

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

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

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: <p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. This includes the 42 serviced apartments being approved for rest home level use. There is a designated external smoking area.</p> <p>Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.</p>

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There are policies around restraint, enablers and the management of challenging behaviours, which meet requirements of Health and Disability Sector Standards 2008. The service currently has four residents assessed as requiring the use of restraint and one with an enabler.

The care plans include reference to the use of restraint or enabler (sighted in two files for residents who use restraint (hospital level) and one file reviewed for a resident using rest home level care.

On-going consultation with the resident and family is also identified.

Falls risk assessments are completed on admission and six monthly with a post falls assessment completed after an incident. Strategies are considered to prevent falls and restraint and use of enablers is the last option.

Challenging behaviour assessments are completed as required.

Policy states that enablers should be voluntary and the least restrictive option possible and the five caregivers, restraint coordinator (registered nurse) and the clinical nurse leader are familiar with this.

The file reviewed for the resident with an enabler includes a consent form and documentation around the enabler in the care plan.

Staff received training around restraint minimisation in February and March 2013.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers and the policy has been reviewed last in October 2013.

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

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

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA
Evidence: Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinator (registered nurse) is able to describe the role and responsibilities and there is a job description of the restraint coordinator. Approval for each form of restraint is reviewed at a frequency as determined by the organisational restraint minimisation policy and with reference to resident safety. Two files reviewed (both hospital) evidenced consent forms documented. The use of restraint and enablers is discussed at the monthly quality meeting (meeting minutes sighted), the health and safety monthly meeting and the six monthly restraint approval group meeting.

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

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

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

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

Attainment and Risk: FA
Evidence: <p>The Summerset restraint minimisation policy outlines the organisation approach to managing restraint. This includes the use of a restraint assessment guide by the restraint coordinator and general practitioner, risk assessment, the need to attempt to modify behaviour prior to the use of restraint, resident advance directives, previous tolerance of restraint application, resident medical and social history, cultural considerations, alternatives to restraint use and the goals of the restraint intervention.</p> <p>There is an assessment completed in the two files of residents using restraint (lap belt and bedrails).</p> <p>Family/whanau input and consent is required prior to the application of any forms of restraint at Summerset by the Park – sighted on the assessment forms reviewed.</p> <p>Two of two files document risks on the assessment form associated with the use of restraint.</p> <p>The care plans identify the underlying causes of the relevant behaviour.</p>

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

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

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

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

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

Services use restraint safely

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

Attainment and Risk: PA Low
Evidence: The restraint policy states that the need for restraint use is monitored and reviewed as part of the general practitioner reviews three monthly and as part of the approvals group meeting three monthly when these start and this is documented. Two files reviewed indicates that frequency of monitoring is documented on the review of restraint form and in the care plan. The service reviews individual use of restraint as part of the monthly quality and health and safety meetings and the six monthly restraint meeting. The restraint coordinator (registered nurse) and the nurse manager state that restraint is only used at Summerset by the Park as a last resort after all other

alternative techniques to modify behaviour or manage resident safety have been exhausted. This is outlined as policy requirements in the restraint minimisation policy.

The restraint minimisation policy requires that a restraint register is maintained with all residents' names and restraint details included.

The restraint register is maintained and updated by the restraint coordinator as required.

The time the restraint went on and off is documented on the restraint monitoring form.

An improvement is required to the documentation of monitoring of the restraints.

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

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

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

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

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

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;

- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: PA Low
Evidence: Monitoring forms are at times documented with the time the restraint went on and the time off.
Finding: Monitoring forms are inconsistently documented with the restraint monitoring forms not always include evidence of checks completed.
Corrective Action: Document monitoring of the use of restraint as per timeframes documented in the care plan and in the restraint assessment and review form.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The use of restraining devices is evaluated by the restraint coordinator (registered nurse) and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and general practitioner.

On review of two files where the use of restraint is identified, there is evidence that plans are reviewed six monthly with a general practitioner review three monthly for all residents.

There is an assessment and review of restraint also completed three monthly and this is documented in the two files reviewed.

Restraint use is discussed at the monthly quality and health and safety meetings and six monthly restraint meetings.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Summerset by the Park reviews the use of restraint as part of its internal audit processes. The results of the restraint audit are discussed at the monthly quality meetings and any corrective actions identified are actioned through this forum. The restraint approvals group meets six monthly- meeting minutes sighted for 2013.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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 3.1: Infection control management (HDS(IPC)S.2008:3.1)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control nurse is a registered nurse (clinical nurse leader) who has been in the role for five months with three months in the role as infection control coordinator. Prior to taking on the role, the nurse manager has provided a thorough handover to the new infection control coordinator as described by the infection control coordinator and nurse manager interviewed. The infection control coordinator is supported by the nurse manager, clinical and quality manager at head office and education and nurse manager. The infection control coordinator can access external specialist advice from doctors, laboratories, other Somerset infection control nurses and the District Health Board infection control specialists/gerontologists when required. The infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the infection control coordinator through the quality and health and safety monthly meetings and through the infection control meeting six monthly. There is a job description for the infection control coordinator including the role and responsibilities. There are policies and an infection control manual to guide staff to prevent the spread of infection.

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control coordinator (registered nurse) provides an infection control report to the monthly quality and health and safety meetings (minutes reviewed for 2013).

The infection control coordinator can access external DHB, infection control nurse specialist, Bug Control, laboratories, and general practitioner specialist advice when required.

The infection control coordinator states that there is access to all relevant resident information to undertake surveillance, audits and investigations.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

Summerset by the Park has infection control policies and an infection control manual, which reflect current practise.
D 19.2a: Infection control policies include hand hygiene, standard precautions, transmission-based precautions, outbreak management, antimicrobial usage, prevention and management of infections.
The infection control policy was reviewed last in January 2013.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The previous infection control coordinator completed infection control training through Bug Control in 2013. The new infection control coordinator is booked in to have infection control training in February 2014 noting that she has only been in the position for three months. The infection control coordinator is able to articulate sound knowledge around infection control practices. Staff complete annual infection control education - last provided in April and December 2013. The training folder records the staff education session content and attendance records. External resources, including DHB, laboratory, other Summerset IC nurses and general practitioners ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of resident and visitor education when any issues arise with an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Infection monitoring is the responsibility of the infection control coordinator with a sound understanding of infection surveillance. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset by the Park are appropriate to the acuity, risk and needs of the residents.</p> <p>The infection control coordinator enters infections on to the infection register and infection information is entered into the Summerset database, which generates a monthly analysis of the data. The analysis is reported to the monthly quality and health and safety meetings that include a cross section of staff (minutes viewed).</p> <p>Communication between the facility's primary and secondary services regarding infection control is reportedly responsive and effective as stated by the nurse manager. The general practitioner interviewed confirmed that staff provide information about any changes in state for a resident including if there are infections and confirms that instructions are followed up. There is evidence of general practitioner involvement and laboratory reporting in the resident files reviewed.</p>

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

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

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

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

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

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

