

Lister Home Incorporated

Current Status: 29 October 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit; Verification 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

Lister Home provides rest home and hospital level care for up to 62 residents. On the day of the audit, there were 57 residents (37 at rest home level and 20 at hospital level). The service is managed by an experienced nurse manager. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed all eight of their certification shortfalls around advance directives; documentation of meeting minutes and internal audit summaries; resident assessments; care plan evaluations; use of short term care plans; transcribing of medication orders; and restraint/enabler assessments.

This surveillance audit identified that improvements are required relating to recording of allergies on medication files, and medication competencies for registered nurses (RNs).

A verification audit of a new 14 bed rest home unit was also conducted. The service is currently underway with a staged redevelopment of the older area of the home. Certificate for Public Use has been issued by local council and the unit is now fully occupied. The assessment of the new unit identified improvements required relating to secure chemical storage, and completion of the outside environment of the new unit.

Audit Summary as at 29 October 2013

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded

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

Consumer Rights as at 29 October 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 29 October 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 29 October 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 29 October 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 29 October 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 29 October 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 3.9)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of 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:	Lister Home Inc
Certificate name:	Lister Home and Hospital
Designated Auditing Agency:	HDANZ
Types of audit:	Spot Surveillance and Verification
Premises audited:	Lister Home and Hospital ; Innes Street, Waimate
Services audited:	Hospital, Medical, Rest Home Aged Care
Dates of audit:	Start date: 29 October 2013 End date: 29 October 2013
Proposed changes to current services (if any):	Rebuild of old rest home area currently underway. Stage one and two complete which included demolish of old rest home area and rebuild of 14 bed units. Stage three work in progress. The surveillance audit included verification of the new 14 bed rest home unit. A small part of the old rest home remains as it adjoins the new unit with four rest home rooms included. The capacity for the service is now 62 residents.

Total beds occupied across all premises included in the audit on the first day of the audit:	57
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Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	5
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
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	16	Total audit hours off site	11	Total audit hours	27
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Number of residents interviewed	7	Number of staff interviewed	10	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	75	Number of relatives interviewed	4
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 the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Monday, 18 November 2013

Executive Summary of Audit

General Overview

Lister Home provides rest home and hospital level care for up to 62 residents. On the day of the audit, there were 57 residents (37 at rest home level and 20 at hospital level). The service is managed by an experienced nurse manager. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed all eight of their certification shortfalls around advance directives; documentation of meeting minutes and internal audit summaries; resident assessments; care plan evaluations; use of short term care plans; transcribing of medication orders; and restraint/enabler assessments.

This surveillance audit identified that improvements are required relating to recording of allergies on medication files, and medication competencies for registered nurses (RNs).

A verification audit of a new 14 bed rest home unit was also conducted. The service is currently underway with a staged redevelopment of the older area of the home. A Certificate for Public Use has been issued by the local council and the unit is now fully occupied. The assessment of the new unit identified improvements required relating to secure chemical storage, and completion of the outside environment of the new unit.

Outcome 1.1: Consumer Rights

Open disclosure is inherent in the day-to-day operations of the service. Families report that they are always informed when their family member's health status changes or of any other issues or adverse events arising.

Complaints processes are implemented. Complaints and concerns are actively managed and well documented. Improvements have been made since previous audit to advance directive documentation.

Outcome 1.2: Organisational Management

Lister Rest home and Hospital has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with other similar aged care facilities. Corrective actions are identified and implemented. Improvements have been made since previous audit to meeting minutes and internal audits.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed.

There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The inservice education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents. The recent employment of a clinical coordinator/RN will provide additional RN cover for the four additional hospital-level rooms.

Outcome 1.3: Continuum of Service Delivery

Lister Rest home and Hospital has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning, care plan evaluations and that the interventions noted in the care plans are consistent with meeting residents' needs. A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. The previous audit identified that there had been gaps around completion of assessments, care plans developed based on assessments, the use of short term care plans, and conducting comprehensive evaluations. These areas have been addressed and monitored by the service. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is an appropriate medicine management system in place. The previous audit identified transcribing of medication orders to care plans – this has been addressed and monitored by the service. Further areas identified for improvement include recording of allergies or nil known allergies on medication charts and developing a documented RN medication competency observation assessment.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis.

Verification audit: the service is well placed to continue to provide nutritional requirements for residents.

Outcome 1.4: Safe and Appropriate Environment

The facility is purpose built. All building and plant have been built to comply to legislation. The service displays a current building warrant of fitness.

Verification audit: Lister Home and Hospital has been undergoing a staged redevelopment of the rest home area. A new 14 bed unit was completed in June 2013 following part demolition of the old rest home unit. Four beds remain in the old rest home unit which adjoins the new 14 bed unit via two corridors. The new 14 bed unit has single full ensuite rooms which are now fully occupied. A tour of the laundry evidenced that

chemicals are not stored safely and securely – improvements are required in this area. Internally, the physical environment of the 14 bed unit and fixtures and fittings of the new resident rooms are appropriate and safe. The 14 rooms for verification are spacious and provides sufficient space to enable the use of mobility equipment. Improvements are required whereby the external environment is completed including lawns, permanent fencing and walkways. There are cleaning and laundry policies and procedures that continue to be monitored and adhere to safety standards. A Certificate for Public Use has been acquired by local council. Furniture and fittings have been selected with consideration to residents' abilities and functioning and rooms are personalised. The service has implemented policies and procedures for civil defence and other emergencies and fire drills are conducted. Staff receive training in first aid and are able to respond to emergency situations. There is a new call bell system in the new area which is fully operational. Fire alarms, smoke detectors and sprinkler system have been installed and are fully functioning. General living areas are heated via heat pumps and ducted heating system and resident rooms are heated via underfloor heating, with windows providing ventilation. Shortfalls have been identified relating to: the new 14 bed unit being occupied prior to verification audit being conducted and approval confirmed by Healthcert, and an approved fire evacuation scheme for the new unit.

Outcome 2: Restraint Minimisation and Safe Practice

Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. There are seven residents on the restraint register who are using a restraint (bed rails) and two residents who are using an enabler (bed rails). The use of enablers is voluntary, requested by the resident.

There is evidence of a full restraint assessment prior to implementing the enablers. This previously identified shortfall is now being met.

Outcome 3: Infection Prevention and Control

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

Verification audit: There are policies and procedures in place relating to Infection prevention and control that support the Infection Control standards. There is a designated Infection control nurse who reports to the management team. Infection prevention and control is part of the risk management plan developed for the staged rebuild of the facility.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	23	0	3	1	0	0
Criteria	0	54	0	3	2	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	23
Criteria	0	0	0	0	0	0	0	42

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low			
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	New 14 bed rest home unit was utilised without proper procedure followed – verification of 14 bed unit and approval from HealthCERT that unit could be occupied.	In future, all new bed configurations, new builds, refurbishment must be certified fit for use and approved by HealthCERT prior to occupancy.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	a) Enrolled nurse in the rest home area has not completed medication competency prior to assessing care giving staff; b) registered nurse medication competency does not include observation of practice.	a) Ensure that assessment of care staff is undertaken by appropriately trained and competent staff member; b) review RN medication competency to include observation of practice.	60
HDS(C)S.2008	Criterion 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.	PA Low	Five of 12 medication charts reviewed did not record whether the resident has allergies or sensitivities.	Ensure all medication charts record details of allergies/sensitivities or nil know allergies.	30
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.4.1.1	Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Moderate	Chemicals in the laundry area are not stored securely.	Ensure all chemicals are stored securely to minimise risk of harm to residents.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	Garden and lawn area directly outside the new unit is not completed. There are uneven surfaces and unfinished pathways.	Complete the external environment to ensure residents are provided with safe and accessible external areas that meet their needs.	90

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Consumers are informed of their rights.

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

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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: Not Audited
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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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: Not Audited
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: Not Audited

Evidence:

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: Not Audited

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 1.1.7: 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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
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, a complaints policy and an incident/accident reporting policy.</p> <p>Seven residents (five rest home, two hospital) and four family members (one rest home, three hospital) report they were welcomed on entry and were given time and explanation about the services and procedures. Resident/relative meetings occur three times each year. The nurse manager is readily accessible, confirmed in interviews with three caregivers (one rest home and two hospital), seven residents (five rest home level and two hospital level) and four relatives (one rest home, three hospital).</p> <p>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.</p> <p>D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>D16.4b The four family members (one rest home, three hospital) interviewed state that they are always informed when their family member's health status changes or of any other issues arising. Evidence of open disclosure to the resident and relatives was verified in all 14 of the 14 accident/incident forms</p>

reviewed.

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:

Previous audit identified a shortfall relating to appropriate completion of advanced directives. The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Staff are familiar with the code of rights and informed consent and described the link between Lister Home's philosophy and choice and consent on a daily basis. Informed consent forms are evident on all resident files reviewed. There is a resuscitation policy and advance directive policy and associated forms. Five of five files reviewed confirmed that resuscitation forms are either completed by the resident or a medically initiated resuscitation order is completed. No evidence of family signing resuscitation orders. The service has made improvements in this area.

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: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: Not Audited
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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
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: Not Audited
Evidence:

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

Consumers have access to visitors of their choice.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: Not Audited
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:

There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. Residents (five rest home and two hospital) and four family/whanau (one rest home and three hospital) confirm they are aware of the complaints process and they would feel comfortable lodging a complaint to the nurse manager if necessary.

There is a complaints register that is up to date and includes relevant information regarding the complaint. Verbal complaints are included. A complaints folder is maintained. Three complaints were lodged in 2012 and one complaint has been lodged to date in 2013. All documentation including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder. Records demonstrate that complaints are actively managed by the nurse manager.

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

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

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

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: PA Low
Evidence: <p>Lister Home provides care for up to 62 residents at hospital (geriatric) and rest home level care. This includes one bed that is available for respite care and three beds that are available for palliative care. Seven beds are swing beds that can accommodate either a rest home level or hospital level resident. On the day of the audit, there were 57 residents in total (37 residents at rest home level and 20 residents at hospital level including one receiving palliative care). This aged care facility is an Incorporated Society that is governed by 12 Board members. The board meets monthly. The nurse manager reports directly to the board.</p> <p>There is strategic plan 2012-2013 that includes a vision, mission, strategic environment and strategic goals. The stated mission states 'we aim to be a progressive healthcare organisation, open and adaptable to the changing needs of the older members of our community always actively representing their interests and seeking with modern facilities to provide them with a safe, comfortable and caring environment'. A documented philosophy explains how this is achieved in practice.</p>

Lister Home has well established quality and risk management systems.

The service is managed by an experienced nurse manager (registered nurse) who has been in this position for four years. The nurse manager holds a Bachelor of Nursing Degree and a diploma in care of the elderly. She has completed a number of postgraduate papers. She is supported by a team of experienced, registered and enrolled nurses. A clinical coordinator (RN) has recently been employed and begins work three days a week on 31 Oct 2013. The nurse manager reports this addition of a clinical coordinator is related to the recent increase in the number of beds. The nurse manager attends more than eight hours annually of professional development relating to the management of an aged care environment. She recently attended the Aged Care Conference in Auckland.

Verification audit: The governance structure is well placed to continue to provide support and strategic guidance to management in the provision of safe services. However, it is noted that the service did not obtain approval from Healthcert in relation to verification of the new 14 bed unit prior to its opening and occupancy in June 2013.

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

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

Attainment and Risk: PA Low

Evidence:

Verification audit: While the governance and management structure is well placed to continue to provide aged care services, it is noted that adherence to correct procedure in relation to verification of the new 14 bed unit has not been followed. The new unit was completed in May 2013 with residents occupying the unit from June 2013 onwards.

Finding:

The new 14 bed rest home unit was utilised without proper procedure followed – verification of 14 bed unit and approval from Healthcert that unit could be occupied.

Corrective Action:

In future, all new bed configurations, new builds, refurbishment must be certified fit for use and approved by Healthcert prior to occupancy.

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

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

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

Attainment and Risk: 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: Not Audited
Evidence:

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: Not Audited
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
<p>Evidence:</p> <p>The service has a strategic plan and quality improvement plan that are implemented. The quality system and internal audit programme is designed to monitor contractual and standards compliance and the quality of service delivery. The monthly, quarterly and annual reviews of this programme reflect the service's commitment to continuous quality improvement. There is an internal audit schedule in place. There is evidence of the regular monitoring of a wide variety of aspects of the service via this internal audit schedule with a total of 43 types of internal audits that take place each year with varying frequency. In addition, there is a quality improvement log that has lodged 22 quality initiatives year-to-date for 2013. An example of a recent quality initiative is the benchmarking of quality and risk management data against 11 similar aged care facilities.</p> <p>Feedback and progress relating to quality and risk management systems is provided during six-weekly quality assurance/health and safety meetings, monthly registered nurse/enrolled nurse meeting, and three monthly staff meetings. The quality assurance/health and safety meeting includes (but is not limited to) feedback pertaining to: internal audits; quality initiatives; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; education. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. This, together with comprehensive staff training, demonstrates Lister Home's commitment to on-going quality improvement. Discussions with one registered nurse (hospital), one enrolled nurse (rest home) and three caregivers (one rest home and two hospital) confirm their involvement in the quality programme. This previous partial attainment is now being met.</p> <p>Resident/relative meetings take place three times each year.</p> <p>D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy</p>

and procedures is detailed to allow effective implementation by staff. The reviews of the policies and procedures are scheduled to be completed on an annual basis.

D5.4 The service has the following policies/procedures to support service delivery. Policies and procedures align with the resident care plans.

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

There is a comprehensive infection control manual. There is a restraint policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.

A document control system is in place. Documents no longer relevant to the service are removed and archived. Policies and procedures that are updated are documented on a document control sheet that is held in the front of each policy manual. The nurse manager reports staff are made aware of policy updates on the Time Target communication system and copies of policy updates are posted in the staff room.

The service collects information on resident incidents and accidents, and staff incidents/accidents. Incident/accident forms are completed and given to a registered nurse who completes the follow up. All incident/accident forms are seen by the nurse manager who completes any additional follow up and collates and analyses data to identify trends. Data is being benchmarked against 11 other aged care facilities. Results are discussed with staff through the six-weekly quality assurance/health and safety meetings, monthly registered nurse/enrolled nurse meeting, and three monthly staff meetings.

Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through resident/relative meetings and surveys are followed up and actioned. Data is being benchmarked against 11 other aged care facilities.

Infection control data is collated monthly and report to staff. Three caregivers interviewed are well informed about infection control. Data is being benchmarked against 11 other aged care facilities.

Actual and potential risks are identified and corrective actions initiated. There is a hazard register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually.

Restraint/enablers are reviewed at the six monthly restraint approval group meetings and six-weekly quality assurance/health and safety meetings.

A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually.

Lister Home holds six-weekly quality assurance/health and safety meetings, monthly registered nurse/enrolled nurse meetings and three monthly staff meetings.

Internal audits are completed and include the identification of any issues and corrective actions where required. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored. Resident/relative meetings occur three times each year. Annual resident satisfaction surveys and family satisfaction surveys are completed.

Corrective actions are established as a result of internal audits, quality initiatives, incidents, accidents, complaints and concerns.

Discussions with one registered nurse, one enrolled nurse, three caregivers, seven residents (five rest home, two hospital) and three family members (one rest home, three hospital) demonstrate that corrective actions are implemented. Corrective actions are documented on the internal audit form, quality improvement log, and meeting minutes. There is evidence of sign-off by the nurse manager when corrective actions are completed. This previously identified shortfall is now being met.

D19.3 There are implemented risk management and health and safety policies and procedures in place including incident/accident and hazard management.

The health and safety policies include (but are not limited to): hazard identification; hazard management; staff responsibilities; employee participation in health and safety systems. The policy requires that all staff are informed of significant hazards and how to eliminate, isolate or minimise the impact of the hazard. There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate. Internal audits are completed across a range of areas to identify risks.

D19.2g Falls prevention strategies are in place, which include the analyses of falls, incidents and the identification of interventions to minimise future falls.

Improvement Note:

A selection of policies fails to reflect regular reviews with some policies not having a review since 2010. The nurse manager reports policy reviews have actually occurred on an annual basis but the footer section has not been consistently updated to reflect this.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the

status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Discussions with the nurse manager confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications. D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents.</p> <p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident by the individual witnessing the event, with immediate action noted by the registered nurse on duty and any follow up action required. The nurse manager signs off on all adverse events. Minutes of the six-weekly quality assurance/health and safety meetings, monthly registered nurse/enrolled nurse meetings and three monthly staff meetings reflect a discussion of incidents/accidents and actions taken. Fourteen completed incident/accident forms were randomly selected for review. Investigations are conducted by the registered nurse. Both RN and manager sign the forms when the investigation is completed. Accident and incident forms provide evidence that families are kept informed as confirmed on family interviews.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including registered nurses and general practitioners is kept. Current practising certificates were sighted for all registered health professionals (registered nurses (10), enrolled nurse (1), GPs (4), OT, physio and dietitian).

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (two registered nurses, one enrolled nurse, three caregivers, one cleaner). Reference checks are completed before employment is offered and are evident in staff files reviewed. Police vetting is routinely carried out.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Three caregivers were able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the nurse manager for staff who require additional training. Orientation programmes are specific to the service type (eg, RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all seven staff files audited).

Discussion with the nurse manager, one registered nurse (hospital), one enrolled nurse (rest home) and three caregivers (one rest home and two hospital) confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an education plan 2012 and 2013. The annual training programme exceeds eight hours annually. Additionally, all caregivers are required to undertake aged care education within three months of commencement of employment. The registered nurses attend external training including conferences, seminars and sessions provided by South Canterbury District Health Board (SCDHB).

In 2013 (year-to-date) there have been 13 in-service training sessions provided for staff including: incontinence (21 staff attended); infection control (28); nutrition (17); falls prevention (23); complaints (20); privacy (16); health and safety (33); challenging behaviours (25); palliative care (19); elder protection (12); syringe driver (13); chemical safety (10). Efforts are undertaken by the nurse manager to ensure in-service education is regularly attended by staff (evidenced in interviews with the nurse manager, registered nurse, enrolled nurse and three caregiver staff). Meeting minutes (quality/health and safety; RN/EN; staff) reflect staff being strongly encouraged by the nurse manager to attend training.

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:

There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Time Target is used to build staff rosters. Interviews with one registered nurse (hospital), one enrolled nurse (rest home) and three caregivers (one rest home and two hospital), seven residents (five rest home, two hospital) and four family members (one rest home, three hospital) identify that staffing is adequate to meet the needs of residents. The nurse manager works full-time Monday-Friday 08.00-17.00 plus on call every day. A clinical coordinator (RN) has been employed three days per week effective 31 October 2013. This additional staff is the result of the expansion of the facility by four hospital beds.

An occupational therapist is employed six hours per week and a physiotherapist is contracted to provide services four hours a week.

The hospital wings are staffed with an RN 24 hours a day, seven days a week with an additional RN on the AM shift two days a week. This RN cover is in addition to the nurse manager (and recently employed clinical coordinator).

An enrolled nurse oversees the rest home wings during the AM shift with a senior caregiver on staff for the PM and night shifts.

Caregiver staffing fully complement the service meeting ARC contractual requirements. The nurse manager reports staff numbers are adjusted based on resident acuity and the occupancy rate.

Verification audit: there is currently no requirement for an increase in staff levels as resident numbers remain unchanged. However, the service has developed rosters to reflect an increase in staffing levels for full occupancy of 62 residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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: Not Audited

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 1.2.9.7 (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: Not Audited
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: Not Audited
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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

ARHSS D4.2

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
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: FA

Evidence:

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long term care plans are to be completed within three weeks and align with the service delivery policy. Five files were reviewed (three rest home and two hospital). Five of five long term care plans were completed within the three week time frame and appropriate assessments have been completed for all identified issues.

Wound care assessments and treatment plans were reviewed and included four hospital residents and one rest home resident. Wounds included two pressure areas on heels, one lymph node wound, and one ulcer on an ankle and one rest home resident with chronic venous ulcers. Activity assessments and activities care plans have been completed by the activity staff.

Staff were familiar with the timeframes and files reviewed were kept up to date. InterRAI assessment tool is not currently in use, however, the nurse manager has completed InterRAI training and further RN staff are in the process of completing.

D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours. A long term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months.

D16.5e; Medical assessments were documented in five of five long term files reviewed within 48 hours of admission. Three monthly medical reviews were documented in all five files by general practitioner. It was noted in all five resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly. On interview the GP advised that residents are seen three monthly or more frequently if required. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

Assessment tools available for completion on admission include a) pressure area risk assessment, b) pain assessment and pain charts, c) challenging behaviours and monitoring forms, d) continence assessment, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a Handover form which is completed for each shift that lists staff allocations, notes any residents requiring any special observations or needs. GP's from two medical practices in Waimate provide the service with visits to residents. On interview, the GP (with majority of residents) advised that she visits the service weekly. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Five files reviewed evidence this is occurring. A daily clinical management meeting provides an opportunity to discuss any clinical issues.

The physio visits weekly and is contracted for four hours. Activities staff and an occupational therapist who visits weekly provides physio support as directed by the physio.

One GP interviewed stated that the service is prompt at informing of changes in the residents conditions and that instructions are carried out.

Tracer Methodology: Hospital resident

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

Tracer Methodology: Rest Home resident

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

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

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

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

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

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

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

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

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

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

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:

Previous audit identified that risk assessment tools were not fully utilised for all resident files reviewed. Assessments in use include a comprehensive initial assessment, risk assessments for pain, nutrition, behaviours, continence, falls risk, and pressure area risk. Of the five files reviewed (three rest home and two hospital) assessment documentation includes five of five continence, nutrition, falls risk, and pressure risk assessments are completed. Three of five residents with pain issues have pain assessments completed and one of five residents with known challenging behaviours has behaviour assessment and monitoring completed. Wound assessments and treatment charts are completed for five residents with wounds. Care plans reflect the level of care residents require and are being implemented by care staff and are supported by comprehensive assessment processes. This is an improvement from the previous audit.

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

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:

Previous audit identified short falls in relation to care plans not being based on assessments and the use of short term care plans. Five resident files were reviewed – three rest home and two hospital. The three rest home residents whose files were reviewed were: one with challenging behaviours and chronic wounds; one with high falls incidence and risks and chronic pain, one with falls incidents, dementia and depression. The two hospital residents files reviewed were: one with end stage COPD and short term memory loss; and one palliative care resident. Care plans are individualised and personalised to reflect needs, goals and outcomes. Resident files include; a) admission form, b) assessment forms and reviews, c) informed consent d) family communication sheet, e) progress notes f) medical visits/notes and allied health notes, g) short term treatment sheet, h) long term care plan, i) correspondence, j) lab forms, k) infection forms, l) incident forms, m) advanced directives and n) social history and diversional therapy plan.

There is a long term care plan that includes; problem/need, objectives, interventions, evaluation for identified issues. The care plan includes: personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture, medication, controlling pain, sleeping patterns/rest, intimacy/sexuality, communication, skin/wound care, breathing, memory loss/confusion, challenging behaviour, special needs. There is evidence of input and records from physiotherapist, occupational therapist, podiatry, dietitian and medical staff.

Seven residents (five rest home, two hospital) and four family (one rest home, three hospital) interviewed confirmed that they were involved in the development of the person centred care plan. Long term care plans are developed with input from resident and family and are based on assessments conducted and short term care plans are in use for issues such as pain, wounds, infections, and short term changes to health. The service has made improvements in this area.

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Five resident files were reviewed and included three rest home and two hospital residents.

The three rest home residents whose files were reviewed were: one with challenging behaviours and chronic wounds; one with high falls incidence and risks and chronic pain, one with falls incidents, dementia and depression. The two hospital residents files reviewed were: one with end stage COPD and short term memory loss; and one palliative care resident. Care plans are individualised and personalised to reflect needs, goals and outcomes. Resident files include; a) admission form, b) assessment forms and reviews, c) informed consent d) family communication sheet, e) progress notes f) medical visits/notes and allied health notes, g) short term treatment sheet, h) long term care plan, i) correspondence, j) lab forms, k) infection forms, l) incident forms, m) advanced directives and n) social history and diversional therapy plan.

Of the five files reviewed, four of those residents were interviewed and all four reported their needs were being appropriately met. There is a long term care plan that includes; problem/need, objectives, interventions, evaluation for identified issues. The care plan includes: personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture, medication, controlling pain, sleeping patterns/rest, intimacy/sexuality,

communication, skin/wound care, breathing, memory loss/confusion, challenging behaviour, special needs. Care plans were current and interventions reflect the assessments conducted and the identified requirements of the residents. Interview with one registered nurse and one enrolled nurse verified involvement of families in the care planning process. The rest home resident care plans developed by the enrolled nurse and reviewed and countersigned by the nurse manager.

The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives for five of five files reviewed. There were short term care plans in five of five files reviewed and include plans for infections, wounds, skin tears, pain management, changes in health status, return from acute care. Five residents with wounds demonstrate a link between short term care planning and wound management plans.

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

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

Specialist continence advice is available as needed and this could be described.

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

Wound assessment and wound management plans are in place for five residents and include two pressure areas on heels, one axilla wound, and two chronic ulcers. The registered nurse and enrolled nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. One rest home resident with chronic leg ulcers has input from district nursing wound specialist.

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

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

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

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:

There is one occupational therapist who works one day a week and four activities staff who cover Monday to Saturday. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day are displayed on notice boards around the facility. A social profile is completed on admission which forms the basis for the diversional therapy plan. The plan includes goals and ambitions as well as a plan of meaningful activities. The resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities documentation. The programme is evaluated and can be individually tailored according to resident's needs. One activities staff member advised that residents are able to participate in community activities as well as activities in the service itself. Activities include (but not limited to): outings, exercises and yoga, wheelchair walks, school children visits, cooking, music, crafts, shopping, happy hour, reading, and quizzes. The occupational therapist assists residents with the planned mobility and transferring programme as developed by the physiotherapist. Residents were observed enjoying a movie, participating in exercise class, and wheel chair walks. One on one activities are provided for residents less mobile and able. Resident meetings are held three monthly with feedback relating to activities provided at the meeting. All seven residents (five rest home, two hospital) and four family members (one rest home, three hospital) interviewed discussed enjoyment in the programme and the diversity offered to all residents. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

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:

Previous audit identified shortfall in relation to evaluations not describing the degree of achievement of care plan goals and interventions. Three of five care plans reviewed evidenced that the entire care plan evaluations are comprehensive, relate to each aspect of the care plan and record the degree of achievement of goals and interventions. Two of five care plans reviewed have been developed within the past six months and are therefore not yet due for formal evaluation. Care plans reviewed are updated as changes are noted in care requirements. Improvements have been made in this area. Short term care plans are well utilised for rest home and hospital residents. Any changes to the long term care plan are dated and signed. Five of five care plans reviewed included handwritten updates to the plan as needs have changed for certain aspects of the plan.

Short term care plans were sighted for wounds, weight loss, infections, pain management, and short term health issues.

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

D16.3c: All initial care plans were developed with 24 hours of admission and evaluated by the RN within three weeks of admission

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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 1.3.9: 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: Not Audited

Evidence:

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: Not Audited
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 1.3.10: 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: Not Audited
Evidence:

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: Not Audited
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: PA Moderate

Evidence:

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by two staff – one being a registered nurse. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications.

A registered nurse was observed administering medications to the hospital residents, and a senior caregiver was observed administering medications to the rest home residents. Both staff followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in locked treatment room in the hospital area and in the locked nurses' station in the rest home area. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. Previous audit identified that transcribing was occurring on care plans – no evidence of transcribing on 12 of 12 medication administration signing sheets and on five of five care plans reviewed. The service has made improvements in this area.

Controlled drugs are stored in one locked safe inside a locked treatment room in the hospital unit. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly and stock is conducted six monthly. Medication fridge's are monitored daily and recorded weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 12 drug charts reviewed. Allergies or nil known allergies are recorded on seven of 12 medication charts reviewed - improvement is required in this area.

An annual medication administration competency is completed for senior care givers. The enrolled nurse in the rest home assesses the staff as competent or not, however, this staff member does not complete a medication competency assessment herself. Advised that all staff administering medication must attend compulsory training. The registered nurses are assessed by the nurse manager as part of their annual performance appraisal; however, this does not include observation of their practice. Improvements are required in this area. Medication training due on 31-Oct-13. Competencies for three care staff were reviewed. There is a self-medicating resident's policy in place. A self-medication assessment checklist is available. There are currently no residents who self-administer medications.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b)

signed and dated and c) able to meet acceptable good practice standards. PRN medication orders all record indications for use.
D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

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: PA Moderate
Evidence: An annual medication administration competency is completed for senior care givers. The enrolled nurse in the rest home assesses the rest home care staff as competent or not, however, this staff member does not complete a medication competency assessment herself. Advised that all staff administering medication must attend compulsory training. The registered nurses in the hospital area are assessed by the nurse manager as part of their annual performance appraisal; however, this does not include observation of their practice. Medication training due on 31-Oct-13. Competencies for three caregivers were sighted as current.
Finding: a) Enrolled nurse in the rest home area has not completed medication competency prior to assessing care giving staff; b) registered nurse medication competency does not include observation of practice.

Corrective Action:

a) Ensure that assessment of care staff is undertaken by appropriately trained and competent staff member; b) review RN medication competency to include observation of practice.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts as evidenced in 12 medication charts reviewed (seven rest home and five hospital). Resident photos are on all 12 drug charts reviewed. Allergies or nil known allergies are recorded on seven of 12 medication charts reviewed. Five medication charts did not record whether the resident has allergies or sensitivities.

Finding:

Five of 12 medication charts reviewed did not record whether the resident has allergies or sensitivities.

Corrective Action:

Ensure all medication charts record details of allergies/sensitivities or nil know allergies.

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

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

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

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

Attainment and Risk: FA**Evidence:**

All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller, a freezer and a pantry. The menu is designed and reviewed by a Registered Dietitian (last conducted May 2013). There is a four weekly winter and summer menu Feedback from residents and families was positive. Family survey conducted in January 2013 scored dietary service at 100%. Resident response (27/28) to food service in resident survey of January 2013 rated meals as very appetising. The service provides 50 meals on wheels to the community and has a current local council certificate which expires 30-June-2014.

All meals are cooked in the main kitchen and are served to rest home residents in the adjoining dining room and on trays to the hospital residents. Staff were observed wearing head covering and gloves while serving food. Staff were observed assisting residents with their lunch time meals and drinks.

Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by ECOLAB. There is a food service manual and cleaning schedules. Food in fridges, freezer and pantry are labelled and dated. Decanted food is dated and time for rotation is recorded. Cleaning schedules are implemented.

Nutritional assessments are conducted on all residents and the kitchen staff are informed of dietary requirements. Residents with special dietary needs are catered for. Nutritional assessments are reviewed six monthly as part of the care plan review. Changes to residents dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the whiteboards which are able to be viewed only by kitchen staff.

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

Verification audit: The service is well placed to continue to provide nutritional needs of all residents.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Low
Evidence: Verification audit: The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has a system for investigating, recording, and reporting spills of biological material, blood/body substance exposures, and for managing waste. Cleaning trolleys and chemicals in use are stored in a locked cleaners room. Cleaning trolleys are stored there as well. Bulk chemicals are stored in a locked shed. There is an incident reporting system that includes investigation of waste or hazardous substances incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff including gloves, aprons, gowns and eye protection. Chemical safety training was provided by Ecolab on 10-Sept-13. The laundry is not locked and cleaning chemicals were noted to be housed on open shelves. Improvement is required in relation to safe storage of chemicals.

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

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

Attainment and Risk: PA Moderate
Evidence: On a tour of the facility it was noted that the laundry area is not locked. Chemicals were observed on open shelving within the laundry which is close to the old rest home area of the facility.
Finding: Chemicals in the laundry area are not stored securely.
Corrective Action: Ensure all chemicals are stored securely to minimise risk of harm to residents.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Surveillance audit: the service displays a current Building warrant of fitness dated 1-Aug-2014.

Verification audit: Regular building maintenance is carried out as per scheduled maintenance programme and as necessary. Records are maintained. There is access to necessary and essential equipment within the service and in the new 14 bed rest home unit. Fire and evacuation drill was last conducted in 21-July-2013. A certificate for public use has been provided by the local council and is dated 6-June-2013. The new 14 bed rest home unit is part of a staged re-development of Lister Home. Stage one and two have been completed which included part demolition of the old rest home area and rebuild of the new 14 bed unit. Further work is currently under way to add another new corridor to join the unit to the main building and for further rest home beds. Furniture and fittings have been selected with consideration to residents' abilities and functioning. Residents have brought in their own furnishings for their rooms. There is sufficient room throughout the 14 bed unit for residents to mobilise safely. Floor surfaces and furnishings are completed. All rooms have full ensuite. Hot water temperatures in the 14 bed unit has been monitored with recordings between 43 and 45 degrees Celsius. Access to the older rest home area, dining room and large lounge is via a corridor. The new unit has two sitting areas and a kitchenette. External areas require completion e.g. lawn, seating, pathways and permanent fencing. Seven rooms on the north side of the unit have external sliding doors which have a paved area directly outside. Beyond this the area is unfinished. Seven rooms on the south side do not have external doors.

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

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

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

Attainment and Risk: 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 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

Attainment and Risk: PA Low

Evidence:

Access to the older rest home area, dining room and large lounge is via a corridor. The new unit has two sitting areas and a kitchenette. External areas require completion e.g. lawn, seating, pathways and permanent fencing. Seven rooms on the north side of the unit have external sliding doors which have a paved area directly outside. Beyond this the area is unfinished. Seven rooms on the south side do not have external doors.

Finding:

Garden and lawn area directly outside the new unit is not completed. There are uneven surfaces and unfinished pathways.

Corrective Action:

Complete the external environment to ensure residents are provided with safe and accessible external areas that meet their needs.

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

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:

Verification audit: All 14 bedrooms in the new rest home unit have full ensuites. There is one visitor toilet. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment in ensuite bathroom facilities. These facilities are appropriate for the client group.

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:

Verification audit: Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents in a hospital stretcher is achievable if necessary and equipment can be transferred between rooms. The 14 new rest home unit bedrooms are large in size and allow movement for residents, staff and any mobility equipment.
--

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:

Verification audit: The new 14 bed rest home unit has a lounge area with kitchenette facilities plus a smaller sitting room. Within the wider facility there is large dining room and large large area. Lounge, dining room seating, and furniture has been purchased and chosen as being appropriate for the residents using the service. Residents are able to access areas for privacy if required. Furniture has been chosen and is appropriate to the setting and is arranged to enable residents to mobilise.

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:

Verification audit: The service has in place policies and procedures for effective management of laundry and cleaning. There is documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audit completed in July 2013 with 100% compliance. Laundry cleaning chemicals are not stored securely as per finding #1.4.1.1. There is a locked cleaning cupboard in the unit to provide safe secure storage of cleaning trolleys and cleaning chemicals.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Verification audit:

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency readiness plan includes fire policy and instructions, emergency plans, bomb threat, earthquake, prowlers and intruders, and civil defence emergencies. Emergency training is included in the orientation. Fire training last provided 17-April-2013. Fire evacuation drill conducted six monthly - last conducted 21-July-2013. The fire evacuation scheme includes the new 14 bed unit. Fire evacuation scheme approved for the whole facility in October 1993. A Certificate for Public Use has been issued by the Waimate District Council. The new 14 bed unit has fire alarms, smoke detectors and fire doors in place. These are fully functional. The facility maintains civil defence packs and emergency lighting, alternative energy, gas barbeque and bottled gas, water supply, blankets and bulk food for three days stored. There is a generator available. Emergency lighting and cooking is available in the event of a power failure. A call bell policy is present. The call bells system is appropriate to the unit and is fully functioning. There are call bells available in the dining and lounge rooms and bathrooms. Visitor and contractors sign in is required. There is a security policy. The service secures the buildings at nightfall. Advised by nurse manager and maintenance person that staff complete security checks each evening. Fire exits are automatically locked at 8pm and are linked to the emergency system.

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

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: Verification audit: lounge, sitting area and corridors in the 14 bed unit are heated via a heat pump and ducted ceiling heating vents. The 14 resident rooms are heated with under floor heating and can be controlled individually. Residents have access to natural light in their rooms and there is adequate lamps and lighting in communal areas.

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:

Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. There are seven residents on the restraint register (who are using a restraint (bed rails) and two residents who are using an enabler (bed rails). The use of enablers is voluntary, requested by the resident. There is evidence of a full restraint assessment prior to implementing the enablers. This previously identified shortfall is now being met. There is evidence of the residents consenting to the enabler. In addition, there is evidence of monitoring of residents who are using enablers.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
Evidence:

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

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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 2.2.5: 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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
Evidence:

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: Not Audited
Evidence:

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

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

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

Attainment and Risk: Not Audited
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: Not Audited
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 3.2: 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: Not Audited

Evidence:

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: Not Audited

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:

Verification audit: Lister Home and Hospital has an Infection Control programme and written policies and procedures that comply with current best practice. There are IC policies infection control manual contains comprehensive information about the programme. The infection control programme was reviewed in October 2012.

D 19.2a: Infection control policies include but not limited to: antimicrobial usage, communicable diseases, definitions and guidelines for identifying infections, governance, hand hygiene, infection prevention and control during building and construction procedures, management of waste and hazardous substances, MRSA, notifiable diseases, outbreak management, sharps containers, single use items, staff with infections, standard precautions, surveillance, transmission based precautions. The risk management plan developed for the re-build includes infection prevention and control.

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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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 surveillance is an integral part of the infection control programme and is described in Lister Home's infection control policy. Monthly infection data is collected for all infections. All infections are entered on to a computerised infection register. This data is monitored and evaluated. Outcomes and actions are discussed at the monthly infection control meetings, two monthly quality assurance/health and safety meetings, monthly registered nurse/enrolled nurse meetings and two monthly caregiver meetings. Each resident has an individual infection report that includes reporting on skin, eye, respiratory, gastrointestinal and other infections that may be identified. There is an infection register and all infections are documented on the computer. The report identifies risks, trends and evaluation with implementation of strategies for prevention or minimisation of infection if required. A registered nurse is the designated Infection control nurse.</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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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