

Selwyn Care Limited - Gracedale Hospital

Current Status: 20 February 2014

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

General overview

Selwyn Gracedale Hospital provides rest home and hospital level care for up to 36 residents. On the day of audit there were 13 rest home residents and 23 residents receiving hospital level of care. The acting facility manager is responsible for the overall management of the facility and has been in the role since November 2013. She is a registered nurse (RN), health quality consultant and lead auditor. A permanent facility manager's position is currently being advertised. In the absence of the facility manager, a clinical coordinator/registered nurse is in charge.

Gracedale Hospital implements the Selwyn quality and risk management framework. Quality goals align with Selwyn strategic goals and business plan and are based on care, quality, training, staff and fiscal responsibility. Quality data is collected monthly with results provided to staff through staff and registered nurse meetings.

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

Improvements are required to the following: reassessment six monthly, updating of care plans to reflect cares required including changes in dietary requirements following dietitian review and documentation of allergies.

Audit Summary as at 20 February 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 20 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 20 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 20 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 20 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 20 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 20 February 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 20 February 2014

Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and how to lodge a complaint is available to residents and their family. The resident's cultural, spiritual and individual values and beliefs are assessed on admission.

Informed consent policy and processes are implemented by the service, meeting contractual requirements. Staff ensure residents are informed and have choices related to the care they receive.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

Organisational Management

Services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents.

Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training needs are being met by the organisation. Residents receive appropriate services from suitably qualified staff.

Continuum of Service Delivery

The service has admission and entry policies and procedures. Needs assessment approval is required prior to entry for rest home and hospital level of care. Service information is made available on enquiry and additional information is available on admission. Residents/relatives confirmed the admission process and the admission agreement was discussed with them.

The clinical coordinator and registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provide evidence that the registered nurse has completed an initial assessment and care plan on admission. There is evidence of resident/family participation in the development of the care plans. Long-term care plans are reviewed at least six monthly. The general practitioner examines the resident within 48 hours of admission and three monthly thereafter or as otherwise indicated. Resident files include notes by the general practitioner and allied health professionals.

There are policies and procedures for medicine management. Registered nurses are responsible for the administration of medicines and complete annual medication competencies and education.

Links with the community are maintained and van outings are arranged on a regular basis. Planned activities are suitable to meet the needs of the residents.

All food is cooked on site with the food service sub-contracted. Residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented and the menu plans have been reviewed by a dietitian. The chefs are qualified and all staff have undertaken food safety and hygiene training.

Improvements are required to the following: completion of assessments six monthly, updating of care plans to reflect cares required that are already documented in the evaluations, updating of care plans to include changes in dietary requirements following dietician review and documentation of allergies.

Safe and Appropriate Environment

There are documented procedures for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers.

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

There are adequate numbers of accessible toilets/bathing facilities, lounges/dining areas and activities room. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely.

Documented systems are in place for essential, emergency and security services with alternative energy and utility sources maintained.

Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place that is linked to the residents' care plans. Any restraint/enabler use is recorded in an auditable format. Staff are required to attend restraint minimisation and safe practice education.

At the time of audit, there were nine residents using an enabler and two residents using restraints.

A system of evaluation and review of any restraints/enablers used by residents takes place monthly. Processes are in place for the review of the restraint programme including the review of policies and procedures and review of the restraint education programme for staff.

Infection Prevention and Control

Infection control is integrated as part of the monthly staff and registered nurse meetings. Monthly collation tables from the facility are forwarded to Selwyn head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits with oversight from the acting facility manager. The infection control policies are

comprehensive and reflect best practice. Infection control training is provided to staff at least annually as is hand hygiene training.

There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed. A six monthly comparative summary is completed.

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

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Selwyn Care Limited
Certificate name:	Selwyn Care Limited - Gracedale Hospital
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Gracedale Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 February 2014 End date: 21 February 2014
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit:	36
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Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	14
Other Auditors	XXXXX	Total hours on site	24	Total hours off site	12
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	36	Total audit hours off site	28	Total audit hours	64
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Number of residents interviewed	6	Number of staff interviewed	11	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	33	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 27 March 2014

Executive Summary of Audit

General Overview

Selwyn Gracedale Hospital provides rest home and hospital level care for up to 36 residents. On the day of audit there were 36 residents including, 13 rest home residents and 23 residents receiving hospital level of care. The acting facility manager is responsible for the overall management of the facility and has been in the role since November 2013. She is a registered nurse (RN), health quality consultant and lead auditor. A permanent facility manager's position is currently being advertised. In the absence of the facility manager, a clinical coordinator/registered nurse is in charge.

Gracedale Hospital implements the Selwyn quality and risk management framework. Quality goals align with Selwyn strategic goals and business plan and are based on care, quality, training, staff and fiscal responsibility. Quality data is collected monthly with results provided to staff through staff and registered nurse meetings.

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

Improvements are required to the following: reassessment six monthly, updating of care plans to reflect cares required including changes in dietary requirements following dietitian review and documentation of allergies.

Outcome 1.1: Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers' rights, access to advocacy services and how to lodge a complaint is available to residents and their family. The resident's cultural, spiritual and individual values and beliefs are assessed on admission.

Informed consent policy and processes are implemented by the service, meeting contractual requirements. Staff ensure residents are informed and have choices related to the care they receive.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

Outcome 1.2: Organisational Management

Services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training needs are being met by the organisation.

Residents receive appropriate services from suitably qualified staff.

Outcome 1.3: Continuum of Service Delivery

The service has admission and entry policies and procedures. Needs assessment approval is required prior to entry for rest home and hospital level of care. Service information is made available on enquiry and additional information is available on admission. Residents/relatives confirmed the admission process and the admission agreement was discussed with them. The clinical coordinator and registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provide evidence that the registered nurse has completed an initial assessment and care plan on admission. There is evidence of resident/family participation in the development of the care plans. Long-term care plans are reviewed at least six monthly. The general practitioner examines the resident within 48 hours of admission and three monthly thereafter or as otherwise indicated. Resident files include notes by the general practitioner and allied health professionals.

There are policies and procedures for medicine management. Registered nurses are responsible for the administration of medicines and complete annual medication competencies and education.

Links with the community are maintained and van outings are arranged on a regular basis. Planned activities are suitable to meet the needs of the residents. All food is cooked on site with the food service sub-contracted. Residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented and the menu plans have been reviewed by a dietitian. The chefs are qualified and all staff have undertaken food safety and hygiene training.

Improvements are required to the following: completion of assessments six monthly, updating of care plans to reflect cares required that are already documented in the evaluations, updating of care plans to include changes in dietary requirements following dietician review and documentation of allergies.

Outcome 1.4: Safe and Appropriate Environment

There are documented procedures for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documentation provides evidence there are appropriate systems in place to ensure the residents physical environment and facilities are fit for their purpose.

There are adequate numbers of accessible toilets/bathing facilities, lounges/dining areas and activities room. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely.

Documented systems are in place for essential, emergency and security services with alternative energy and utility sources maintained.

Outcome 2: Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place that is linked to the residents' care plans. Any restraint/enabler use is recorded in an auditable format. Staff are required to attend restraint minimisation and safe practice education.

At the time of audit, there were nine residents using an enabler and two residents using restraints.

A system of evaluation and review of any restraints/enablers used by residents takes place monthly. Processes are in place for the review of the restraint

programme including the review of policies and procedures and review of the restraint education programme for staff.

Outcome 3: Infection Prevention and Control

Infection control is integrated as part of the monthly staff and registered nurse meetings. Monthly collation tables from the facility are forwarded to Selwyn head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits with oversight from the acting facility manager. The infection control policies are comprehensive and reflect best practice. Infection control training is provided to staff at least annually as is hand hygiene training.

There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed. A six monthly comparative summary is completed.

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

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	47	0	3	0	0	0
Criteria	0	98	0	3	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		manner.				
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Two of six files do not have six monthly documentation of reassessment (one documented in March and November 2013 and the second file documented in November 2013 with none prior to this).	Ensure that all assessments are reviewed six monthly or as changes occur.	60
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	(i)The care plans are not updated to reflect care with staff having to read evaluations to identify current practice. (ii) A review of three files indicated that weight is an issue i.e. two for weight loss and one for weight gain and all have had dietitian reviews. While one has a care plan that has been updated to reflect input from the dietitian, the other two have not	(i)Update care plans to reflect cares required. (ii) Update the care plan to reflect changes in dietary requirements following dietitian review.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				been updated.		
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 Low			
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	Documentation in two of four files showed different documentation of allergies between the resident file and the medication file.	Ensure that all resident files include documentation of allergies when these are identified.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: Staff receive education on the Code of Health and Disability Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical coordinator, caregivers and registered nurses confirm their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

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

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

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

Evidence:

A registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at the monthly residents' meetings (meeting minutes sighted). Residents and family interviews confirm their rights are being upheld by the service. Information regarding the Health and Disability Advocacy Service is clearly displayed in multiple locations throughout the facility and in a brochure that is held at reception.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room. Caregivers interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. One particular innovative strategy includes putting a 'do not enter' sign on the resident's door while the resident is with a caregiver having their personal cares done. Residents and families interviewed confirm the residents' privacy is respected.</p> <p>Caregivers interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available one day a week to assess and review residents with restorative potential. Caregivers assist residents with their activity programmes.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to providing guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>There has been one reported instance of abuse at the facility. Police were involved and charges were laid. The person suspected of abuse was immediately suspended and their employment contract was later terminated. Family were kept informed throughout the investigative process.</p>

Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the mandatory education and training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service implements the Selwyn Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/whanau to practise their own beliefs are acknowledged in the Maori health plan. The Selwyn board has a pou tikanga (senior advisor). Local kaumatua (senior member of a Maori tribe) are available through the chaplaincy services.

There are no Maori residents living at the facility during this full certification audit. Staff report there have been Maori residents in the past. Staff interviewed report specific cultural needs are identified in the residents' care plans. This was further evidenced in the six of six resident files selected for review (link 1.3.3). Staff are aware of the importance of whanau in the delivery of care for their Maori residents.

Maori events are linked to the activities programme (e.g. Waitangi Day).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The service identifies each resident's personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. Residents and family/whanau are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident's cultural values and beliefs (link 1.3.3). This information is used to develop a care plan and includes input from the resident and their family/whanau.

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

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

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The facility implements Selwyn Foundation policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes a staff code of conduct and prevention of inappropriate care. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.
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Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

Gracedale Hospital implements Selwyn Foundation policies to guide practice. These policies align with the health and disability services standards. There is a quality framework that supports an internal audit programme. Benchmarking occurs across all the Selwyn Aged Care facilities. The caregivers are encouraged to complete their New Zealand Qualification Authority (NZQA) training and annual mandatory education and training and competencies. There is a monthly Selwyn Foundation manager's forum and regular clinical coordinator forums. Specialised training and related competencies are in place for the registered nursing staff. The Selwyn Foundation sponsors an annual gerontology conference. The Eden Alternative is incorporated into the environment and into the activities programme (link 1.3.7). Residents and families interviewed expressed satisfaction with the care delivered. The GP reports that a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills. Consultation is available through the organisation's nurse practitioner and medical director. A physiotherapist is available one day a week.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in seven of seven completed accident/incident forms. Family/whanau contact is also recorded in residents' files. Interviews with family confirm they are kept informed. Family are invited to attend the monthly residents' meetings.

Interpreter services are available when required from Auckland District Health Board (ADHB). There are no residents currently requiring interpreting services.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has in place policies for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Required consent forms and advance directive forms are evident in six of six resident files reviewed. Discussions with five of five caregivers confirms that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with the clinical coordinator and the registered nurse identifies that staff are familiar with advanced directives and only the resident (deemed competent) can sign the advance directive.</p> <p>D13.1 There are six admission agreements sighted and all have been signed on the day of admission</p> <p>D3.1.d Discussion with family identifies that the service actively involves them in decisions that affect their relatives lives.</p>

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: FA
Evidence: Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. The activities coordinator, responsible for facilitating the monthly residents' meetings, reports information is regularly provided to the residents regarding their right to access advocacy services through HDC. Staff training on the role of advocacy services is included in training on Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings but visitors can arrange to visit after doors are locked. Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church (weekly multi-denominational services). Residents have had their grandchildren's performing groups (brass bands and dancing groups) entertain residents. Residents are included in shopping visits, the Blind Society meetings, the Deaf Society meetings, and outings with families.</p>

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The organisation's complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. Complaint's forms are available at reception. An electronic complaints register is place. In addition, a hard copy register of each complaint received documents the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder.</p> <p>Three complaints lodged in 2013 were selected for review. The first complaint reviewed was lodged with the Health and Disability Commissioner's Office (HDC) on 19 September 2013 relating to a family member complaining about a resident's recurring falls, wound management, clinical management and poor staffing. A full investigation was undertaken. Following the investigation, the HDC reported on 7 November 2013 that staff did not follow appropriate wound care procedures and adverse event reporting procedures and fewer staff were available during the time of the incident than expected staffing ratios. Action plans were implemented to address these concerns, including focused staff education and training. The complaint was signed-off by HDC on 18 December 2013.</p> <p>Two other complaints lodged in 2013 were selected for review. There is documented evidence of timeframes being met for responding to these complaints. One complaint initiated an organisational quality improvement process that has led to the development of a critical incident process (link 1.2.4). The second complaint included appropriate follow-up actions taken including documented evidence of meetings held and a letter of apology by a general practitioner.</p>

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The Selwyn Foundation operates eleven aged care facilities, ten that they own and one, Gracedale Hospital that is managed by the organisation. The Selwyn Foundation is governed by a Board of Trustees. Communication between the Gracedale Board and senior leaders from the Selwyn Foundation takes place on a monthly basis.</p> <p>The Selwyn Foundation has a clear mission, values, and strategic goals. The goals and strategies of Gracedale Hospital align with the Selwyn Foundation goals of charitable mission; continuum of care, centre of excellence; partnerships; brand; environmental sustainability; and financial strength.</p> <p>The facility can provide care for up to 36 residents. All 36 beds can be used for either rest home or hospital-level care. During the audit there are 36 residents living at the facility, 13 residents at the rest home level of care and 23 residents at the hospital level of care.</p>

The acting facility manager is responsible for the overall management of the facility. She has been in the role since November 2013. She is a registered nurse (RN), health quality consultant, and lead auditor (aged care, personal health sector) in addition to other roles within the health sector. Her professional development relating to the management of an aged care facility exceeds eight hours over the three-month period of time that she has been in her acting role. Since the draft report the organisation has advised that the acting facility manager is remaining in that role.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

In the absence of the facility manager, a clinical coordinator/registered nurse is in charge. The current clinical coordinator has been employed at Gracedale Hospital for the past 10 years. The acting facility manager and clinical coordinator are supported by the Selwyn Group Residential Care Manager.
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Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

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

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

Attainment and Risk: FA

Evidence:

Gracedale Hospital implements the Selwyn quality and risk management framework. Quality goals align with Selwyn Strategic Goals and Business Plan (2013-2014) and are based on care, quality, training, staff and fiscal responsibility.

Gracedale implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required and are reviewed, at a minimum, once every two years'. The organisation's nurse practitioner and medical director review all clinical policies. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines.

Policies are readily available to staff electronically on the intranet and in hard copy at the nurses' station. Facility managers peer review all new and revised policies. They are presented to staff for review before implementation. The implementation process includes staff training. The acting facility manager provided an example of a recently revised outbreak management policy that included management and staff consultation and staff training.

Service delivery is monitored through complaints, drug errors, falls, incidents, infections, pressure injuries, soft tissue/wounds, staff accidents, unwanted events and urinary tract infections. Results are benchmarked across all Selwyn aged care facilities. Where audit results are less than the expected threshold, a corrective action process is put into place, which is referred to as a quality improvement project (QIP). QIPs are linked (where applicable) to the NZS 8134 Health and Disability Sector Standard (sighted). An example of a QIP in 2013 that stemmed from an event at Gracedale is the newly developed critical incidents and reporting system (link 1.2.4).

A select group of staff are designated to participate in the internal audit programme. Registered nurses monitor the effectiveness of the clinical services including resident care, clinical documentation, medication management, restraint and enablers, care of medical equipment, emergency medication, and clinical compliance.

Quality data is collected monthly with results provided to staff, evidenced in the staff meeting minutes, and monthly RN forum meeting minutes.

The most recent resident annual satisfaction survey, which was conducted by an external company, took place in November 2013. The overall level of satisfaction rate of residents and families is 78.8%, which is benchmarked across other Selwyn facilities. This is three points below the Selwyn external benchmark. The acting facility manager reports she only recently received the results and has implemented a number of corrective actions that were identified by residents relating to activities (link 1.3.7) and call bells (link 1.4.7).

Corrective actions identified from internal audits that are not entered as a QIP are documented on the internal audit form. Included is a description of the action plan and details of the action taken. Included is the person responsible, due date and sign off when completed.

Examples of corrective actions include findings from an admission process audit whereby on resident expressed dissatisfaction with the choice and quality of meals. Actions included the steps to take to ensure vegetarian meals are prepared for this resident and details included a meeting with the cook to plan meals for this resident.

A second example relates to a restraint/enabler audit where the restraint register documented eleven residents as using restraints. Restraint use was re-evaluated for each resident. The number of residents using restraint lowered to two.

Where corrective actions are put into place, there is documented evidence of communication with staff in the staff meeting minutes and RN meeting minutes. All staff interviewed (five caregivers, two registered nurses including the clinical coordinator, one diversional therapist, one cook, one cleaner, and one laundry staff) report they are kept informed of quality improvements and corrective action plans.

The organisation has a comprehensive risk management plan in place. The risk management plan is generated at a governance level and is regularly reviewed by the Board.

Health and safety policies and procedures, and a health and safety plan are in place for the organisation. The facility holds a current ACC Work Safety and Management Practice tertiary level accreditation.

The health and safety plan is reviewed annually. A hazard management procedure is in place. The hazard register identifies potential hazards. All identified hazards include a risk rating, controls that are in place and monitoring procedures. Health and safety is audited monthly.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The acting facility manager is aware of situations in which she would need to report and notify statutory authorities including: police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are two examples over the past three months where the ADHB was notified. A norovirus outbreak resulted in daily updates to the ADHB. The ADHB has also been kept informed regarding a recent event involving a resident with challenging behaviours and a subsequent call-out to the police

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the facility manager and Selwyn Group residential care manager.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Seven incident reports were selected for review. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event.

A recent initiative that stemmed from an incident at Gracedale Hospital has been the development of the critical incident summary form. This form is now in use across all Selwyn facilities. Adverse event data of a serious nature is entered into an electronic database with regular updates to aid in communication across all sites. Information gathered is regularly shared at the monthly Board meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All seven registered nurses and the acting facility manager hold current annual practising certificates. Visiting practitioner's practising certificates include the GP, podiatrist and physiotherapist.
Six staff files were randomly selected for audit (three caregivers, one diversional therapist, one clinical coordinator and one registered nurse). Appointment documentation is on file including signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process in place. First aid and CPR certificates are held in the registered nurses staff files. Police checks are completed at the head office.
All staff undergo a comprehensive orientation programme (evidenced in all six staff files) that meets the educational requirements of the Aged Residential

Care (ARC) contract.

Caregivers are paired with a senior caregiver for three shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and senior caregivers who administer medicines to residents.

The organisation has a mandatory education and training programme with sessions held monthly. Sessions are provided by the registered nurses, the physiotherapist, and Selwyn Foundation Nurse Practitioner or external speakers. Mandatory topics (14 clinical topics, eight standards topics and 13 health and safety topics) include competencies. Staff attendance records are held on a database and in individual staff files. Staff attendance rates range from 19 participants to 27 participants out of 33 total staff.

Clinical updates are provided by the Selwyn Foundations' nurse practitioner and medical director, the ADHB, the annual Selwyn Gerontology conference and two-yearly Liverpool Care Pathway training.

Five caregivers were interviewed out of the six caregivers who were scheduled to work during the audit. All five caregivers hold basic, advanced and dementia-specific NZQA qualifications (certificates sighted). Education and training hours exceed eight hours a year.

Annual performance appraisals are conducted for all staff, evidence in all six staff files selected for review.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

There is no division of rest home level and hospital level wings.

The rosters for occupancy of 23 hospital level residents and 13 rest home residents is as follows:

The morning shift is staffed with one RN and six caregivers. One RN and four caregivers are staffed on the PM shift, and two caregivers and one RN are staffed on the night shift.

The acting facility manager (RN) works full-time Monday – Friday and the clinical coordinator works full-time, including working every Saturday.

The clinical coordinator reports there are two caregiver vacancies (nights and AM shift) and no RN vacancies. The Selwyn Foundation Bureau provides agency cover on an as-needed basis. The clinical coordinator reports agency use has been approximately 16 RN hours per week, primarily during the PM shifts.

Residents and families interviewed confirm staffing is adequate to meet the residents' needs.

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: FA

Evidence:

The service retains relevant and appropriate information to identify residents and track records. This includes information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed with some information archived and some in the resident files.

D7.1 Entries are legible, include dates and are signed by the relevant caregiver or manager including designation.

Individual resident files demonstrate service integration (six of six reviewed). This includes medical care interventions and records of the activities officer.

Medication charts are in a separate folder with medication and this is appropriate to the service.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive

admission procedure.

Information gathered at admission is retained in resident's records. Residents and family interviewed stated they were well informed upon admission.

The service has a well-developed information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code), how to access advocacy and the health practitioners code.

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this identifies needs and associated risks.

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

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

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

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

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

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

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

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

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

ARHSS D4.2

Attainment and Risk: FA
Evidence: There is a declining entry section in the admission procedure. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

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

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

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; 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:

D16.2, 3, 4: The clinical coordinator or registered nurse undertakes the assessments on admission. The initial support plan is completed within 24 hrs of admission in six of six files sampled (three rest home and three hospital). There is documented evidence that the care plans are reviewed by the clinical coordinator or registered nurse and amended when current health changes.

Of six care plans sampled all have a documented care plan evaluation completed six monthly (refer 1.3.5.2). Within three weeks, the long term care plan is completed by the clinical coordinator or registered nurse as sighted in the six files sampled.

Activity assessments and activities care plans are completed by the diversional therapist in all files reviewed.

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

D16.5e: All six resident files reviewed identify that the general practitioner has seen the resident within two working days. It was noted in the six resident files reviewed that the general practitioner has assessed the resident as stable and is to be seen three monthly that these reviews have occurred alongside as needed reviews.

A range of assessment tools are completed in resident files on admission and completed at least three monthly including (but not limited to); pain, resident mobility scale, safe handling, Braden, falls, continence (refer 1.3.4.2 and 1.3.5.2).

Five caregivers (who worked across all shifts), the clinical coordinator and the registered nurse interviewed describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. A handover was also witnessed and confirms that there is an exchange of information.

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

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

Tracer rest home:

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

Tracer hospital:

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>The care planning policy includes the use of assessment tools that are selected to reflect current best practice. Assessments include (but not limited to) continence assessment, mobility assessment, nutrition assessment, diet request (completed but not updated in response to changes within the six months), pain assessment, falls risk assessment, pressure risk assessment. The needs assessment agency provide a comprehensive needs assessment prior to admission which helps to form the basis of the plan of care.</p> <p>The following personal needs information is gathered during admission (but not limited to): a) personal and identification and next of kin b) ethnicity and religion, c) current and previous health and/or disability conditions, d) medication and allergies, e) activities of daily living, f) equipment needs, g) family/whānau support, h) activities preferences, i) food & nutrition information and j) mental function.</p> <p>Six of six residents (two rest home and four from the hospital) and five of five families from the hospital interviewed report having been involved in the assessment process.</p> <p>All six files included initial admission assessments and on-going assessments are documented with four of six including reassessments repeated at least six monthly where the resident has been at the service for more than six months.</p> <p>An improvement is required to reassessments completed in a timely manner and to update the nutrition assessment and dietary requests as</p>

changes occur.

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

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

Attainment and Risk: PA Low

Evidence:

Initial admission assessments and on-going assessments are documented with four of six including reassessments repeated at least six monthly where the resident has been at the service for more than six months.

Finding:

Two of six files do not have six monthly documentation of reassessment (one documented in March and November 2013 and the second file documented in November 2013 with none prior to this).

Corrective Action:

Ensure that all assessments are reviewed six monthly or as changes occur.

Timeframe (days): 60 (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: PA Low

Evidence:

Six care plans were reviewed for this audit, three hospital and three rest home. Assessment tools relevant to a specific area of the support plan are completed apart from updating of the dietary plans in response to changes identified by the dietitian.

Residents' files include; daily progress notes, recordings - bowel and fluid charts, family contact record, short term care plans/wounds, long term care plans, risk assessments/nutrition, restraint/enabler documentation, care plan evaluations (MDT review), GP initial assessment and visits, lab results, allied health reports/progress notes, activities, consents and advance directives, letters, referrals and archived notes.

Service delivery plans (lifestyle care plans) demonstrate service integration and demonstrate input from allied health including physiotherapist,

speech therapist, general practitioners and podiatrist in six files sampled.
 Notes are maintained by the general practitioner and allied health professionals and significant events, communication with families and notes (as required) are maintained by registered nurses.
 Care plans are comprehensive but not necessarily updated as changes occur. .
 D16.3k: Short term care plans are in use for changes in health status. A short term care plan is documented for example for residents identified as having norovirus in January 2014.
 D16.3f Six of six files sampled (three rest home and three from the hospital) reviewed identify that family are involved.
 An improvement is required to documentation in care plans.

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: PA Low
Evidence: Care plans are documented initially and then the evaluations documented on a separate document with updates of changes in care required identified in the evaluation page. Care plans documented can date back to a year or longer without changes being documented.
Finding: (i)The care plans are not updated to reflect care with staff having to read evaluations to identify current practice. (ii) A review of three files indicated that weight is an issue i.e. two for weight loss and one for weight gain and all have had dietician reviews. While one has a care plan that has been updated to reflect input from the dietitian, the other two have not been updated.
Corrective Action: (i)Update care plans to reflect cares required. (ii) Update the care plan to reflect changes in dietary requirements following dietitian review.
Timeframe (days): 90 (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: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA
Evidence: <p>The service provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. Overall the assessments, care plans and evaluations completed comprehensively (see CAR 1.3.5.2). The care being provided is consistent with the needs of residents, this is evidenced by discussions with the five caregivers, five families from the hospital, the clinical coordinator, the facility manager, one registered nurse. There is a short-term care plan that is used for acute or short-term changes in health status.</p> <p>Six resident files were sampled (three from the rest home and three from the hospital). All six residents had activities of daily living well documented. The progress notes all document that the registered nurse or clinical coordinator has reviewed progress and followed up any outstanding problems identified.</p> <p>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</p>

identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. One file reviewed showed that a behavioural plan is documented to manage wandering with the family included in identifying strategies to manage the resident.

One resident who's file was reviewed is visually impaired and there are extensive strategies documented and implemented to manage care. The resident interviewed confirms that strategies to help get around and negotiate the environment are discussed and implemented.

Two residents with wounds reviewed (one to look specifically at wound management) indicate that each resident has an associated short term care plan which includes a wound management plan and evidence of review every time the dressing is completed.

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

The general practitioner interviewed reports confidence with the service. The general practitioner is available during working hours and outside of working hours as confirmed by the general practitioner and the clinical coordinator.

Staff have had extensive training in 2013 around pain management, wound management, nutrition and hydration, food safety, continence, skin integrity, restraint and dementia.

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 qualified diversional therapist who works full-time Monday – Friday. She has been employed by the service since February 2013 and has six years of experience working in aged care, both in activities and as a caregiver. She attends regular education and training provided by the organisation and externally. She has also received specialised training on the Eden Alternative, a programme dedicated to bringing meaning and fulfilment to the lives of the elderly. She holds a current CPR and first aid certificate and is a qualified New Zealand Qualifications Authority (NZQA) assessor.

Over the course of this audit, residents were observed being actively involved with a variety of activities. The programme is developed each month with weekly plans distributed to the residents and posted in the hallways. This includes monthly outings. The facility has a car and van available for transport.

Residents undergo an activities assessment within two weeks of their admission date, which involves the resident and family/whanau as appropriate, evidenced in six of six residents' files. The assessment includes the resident's life history and past and present interests. An activity plan is developed based on assessment findings. A record is kept of individual residents' participation in activities. The resident's activity plan and involvement in activities is evaluated six-monthly during the multi-disciplinary team meetings.

A range of activities is available to residents and includes one-on-one time with residents who are unable or do not wish to participate with group activities.

A recent resident satisfaction survey (November 2013) has identified several opportunities for improvements relating to activities although this was not a trend that was identified during the audit. Resident and family interviews confirm they are satisfied with the activities programme. To date, the acting facility manager has been meeting with the clinical coordinator and diversional therapist about a quality improvement plan relating to activities.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is evidence of resident and family (where appropriate) involvement in the review of care plans.

D16.4a All care plans sampled are current and there are evaluations completed six monthly.

There are short term care plans to focus on acute and short-term issues. Changes to the long term care plan are made at by documenting changes in the evaluations (refer 1.3.5.2).

ARC D16.3c: All initial care plans are documented by the registered nurse or clinical coordinator 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: FA

Evidence:

D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with the clinical manager identifies that the service has access to (but not limited to); speech language therapist, physiotherapist, diabetic nurse, wound care nurse, needs assessment, and geriatrician and this was evidenced in six files reviewed.

Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

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

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

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made.

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

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

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

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 Low
Evidence: <p>The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Safe Management of Medicines, A Guide for Managers of Old People’s Homes and Residential Care Facilities and the Ministry of Health, Medicines Care Guide for Residential Aged Care 2011.</p> <p>The facility uses monthly supplied Medico medication packs. Medications are checked on arrival at the facility.</p> <p>All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily.</p> <p>Twelve resident medication charts were reviewed and all are identified with photographs and were current. There is no evidence of transcribing and all 12 medication charts sighted have been signed. On 12 of 12 medication administration records non packaged medicines are individually signed as administered.</p> <p>D16.5.e.i.2; Three monthly medication review for the 12 residents is documented in residents medical notes and/or on the prescription chart.</p> <p>Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people and weekly stocktakes occur.</p>

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

There is a self-medicating residents policy available to guide staff practice if required. There are currently no residents self-administering medicines.

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

Allergies are documented in the resident file (not in the medication file).

An improvement is required to documentation of allergies.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

Timeframe (days): (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:

Allergies are expected to be documented in the resident individual file and on the medication sheet in the medication folder. Four of the 12 resident files reviewed had allergies documented. Documentation in the resident file and the medication file matched in two of the four file.

Finding:

Documentation in two of four files showed different documentation of allergies between the resident file and the medication file.

Corrective Action:

Ensure that all resident files include documentation of allergies when these are identified.

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:**

There is a large kitchen and all food is cooked on site by contractors. All staff working in the kitchen have food handling certificates and receive ongoing training from their company.

On admission the registered nurse completes a dietary profile and dietary request and communicates individual resident's needs to the kitchen staff (refer 1.3.5.2). There is a white board with any special diets or needs documented and this is up to date.

Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process and the chef interviewed states that the kitchen is informed of any changes.

There is a daily cleaning schedule in place.

There is a comprehensive kitchen manual in place with six weekly rotation of the winter and summer menus. The menu has been reviewed by a dietician – November 2013.

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

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

Six residents and five family members report a high level of satisfaction with meals.

D19.2 Staff have been trained in safe food handling in 2013.

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

hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Gloves, aprons, and goggles are available for staff. During a tour of the facility protective clothing and equipment was observed in all high risk areas. The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has an accident/incident system for investigating, recording and reporting incidents in a timely manner. There are documented policies; procedures and an emergency plan to respond to significant waste or hazardous substance management. Education has occurred at orientation and through the mandatory training programme.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

Timeframe (days): (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: FA

Evidence:

The building holds a current warrant of fitness, which expires on 30 March 2014. All electrical equipment is checked and tagged annually. A process is in place for upgrading and replacing equipment as required. Fire drills occur six monthly. Documentation and indicators considered during the audit and via sampling supports that the service is meeting the relevant requirements as identified by relevant legislation, standards and codes. There is sufficient space so that residents are able to move around the facility freely. The hallways are wide enough with handrails appropriately placed. Residents were observed moving freely with mobility scooters, walking aids and independently throughout the facility. There are quiet sitting areas in different parts of the facility. All resident rooms and lounges have doors into a courtyard or garden area, which have a ramp for safe access. It was noted on the day of audit that ramp out of the Kiwi wing lounge was incomplete, (this was rectified on the day of audit). External areas are attractively landscaped, well maintained and walk ways are safe. There are grassed areas around the building and outdoor seating with shade.

The five caregivers interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.

Family and residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned.

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

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: <p>There are adequate numbers of accessible toilets/bathing facilities. This includes full ensembles, visitors, toilets and communal toilets conveniently located close to communal areas.</p> <p>Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately, secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Six residents interviewed and five family interviewed report that there are sufficient toilets and showers.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.

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: The service has a lounge, dining area and kitchenette in each of the three units and is easily accessed. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. There is a large accessible lounge, which is used, for activities and a specific area for the hairdresser.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The main laundry service is provided by Selwyn laundry services. Personal laundry is done at the service. There are laundry manuals that include policies/procedures that describe each process for managing laundry, Staff are orientated appropriately in all aspects of laundry management and on-going education occurs on management of waste and hazardous substances. Laundry personnel advised that they had received training in chemical safety, infection control and waste management. The laundry and cleaning service operates seven days a week. The laundry is well managed and dirty to clean flow is evident, with two doors (one entry, one exit). There is a designated cleaners' room for storage of the cleaning trolleys when not in use. Cleaning products and laundry products are well labelled and kept in securely locked cupboards and chemical safety data guidelines are available.</p> <p>The laundry and cleaning service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits have been completed.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>An evacuation plan was approved by the New Zealand Fire Service on 17 May 2005. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with the last drill conducted on 24 December 2013. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures. Registered nurses and the diversional therapist hold current cardiopulmonary resuscitation (CPR) and first aid certificates.</p> <p>All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. A back up battery for emergency lighting is in place. An evacuation list to identify the levels of assistance required for each resident is in place.</p> <p>An electronic call bell system utilises a pager system. There are call bells in all residents' rooms, residents' toilets, and communal areas including the hallways, dining room and hairdressing space. For those residents who are unable to activate a pull-cord, a touch pendant is provided. The recent resident satisfaction survey (November 2013) identified opportunities for improvements relating to responding to call bells.</p>

The acting facility manager is currently investigating these raised concerns.

The doors are locked in the evenings doors can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security.

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

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

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

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

Attainment and Risk: FA

Evidence:

I can put something in

Finding:

Corrective Action:

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

Criterion 1.4.7.6 (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: <p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. There is under floor heating throughout the facility. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.</p> <p>Natural light is provided in all resident rooms and windows are able to be opened. The resident's rooms and lounges had opening rooms into courtyards.</p>

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Procedures include definitions, restraint processes and the use of enablers and restraints. Enablers are defined as voluntary and the least restrictive option. There are two residents using restraint and nine residents using an enabler. All residents who use an enabler undergo an assessment and give consent. Restraint training is included in the induction programme and annual mandatory in-service education programme, which includes staff completing a competency questionnaire. The most recent education session was held in November 2013. One resident using an enabler was selected for review. Evidence of a restraint/enabler assessments, consent and reviews for the use of the enabler is held in the residents' file. Evidence of the use of an enabler is linked to the resident's care plan.</p>

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

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

Attainment and Risk: FA

Evidence:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA
Evidence: The restraint coordinator is a registered nurse. She was on leave during the audit. The clinical coordinator was interviewed in her absence. Restraint assessment and approval processes are in place. The restraint approval group must approve all restraints. This group consists of the GP, restraint coordinator, and clinical coordinator. Restraint is used only as a last resort.

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator or a registered nurse completes restraint assessments for residents who demonstrate that the use of restraint may be indicated. The restraint assessment includes family involvement. Written consent for the use of restraint is provided by the GP, resident/family and restraint coordinator.

One resident file was selected for review. There was evidence of two restraint assessments and written consent for this resident for the use of bedrails and a lap belt. The implementation of restraints for this resident is linked to their care plan.

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

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

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

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

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

Services use restraint safely

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

Attainment and Risk: FA
Evidence: Restraint minimisation policies identify that restraint is only put in place where it is clinically indicated and justified. An assessment form/process is completed for all restraints and enablers. Restraint policy includes a list of approved restraints (lap belts, bed rails, brief restraints, table tops). The frequency of monitoring the use of restraint is included in the restraint assessment and review processes. The resident file selected for review documented two-hourly monitoring while restraint was in use.

The service has a restraint and enablers register for the facility that is updated each month. There are two residents on the register that are using a restraint and nine residents using an enabler. A recent quality initiative involved reducing the number of residents using a restraint on the restraint register from eleven to two.

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

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

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

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

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

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

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

A monthly evaluation of restraint use is completed for each resident using an enabler or a restraint (sighted in two of two residents' files where restraint is being used). The use of a restraint or enabler is linked to the residents' care plans. Multidisciplinary reviews are conducted six monthly. Multidisciplinary reviews include the review of restraint and enabler use (evidenced in two of two residents' files where a restraint or enabler is being used).

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The service actively reviews restraint as part of the internal audit and reporting cycle. A review of the restraint programme, including staff training, restraint register, any incidents relating to restraint use, internal restraint minimisation audit results, and changes to policy, takes place

every two months at Gracedale Hospital and every six months with all Selwyn Foundation Restraint Coordinators.

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

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

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

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

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The clinical coordinator is the infection control (IC) officer and she can access external specialist advice from general practitioners, laboratories and District Health Board infection control specialists when required. The infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed twelve monthly by the IC committee at Selwyn (last reviewed in November 2013).

IC is a standing agenda item at the monthly staff meeting minutes and monthly registered nurse forum meeting minutes (minutes viewed).

Staff are informed about IC practises and reporting. They can contact the IC officer 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC officer and entered into the infection register with the acting facility manager confirming that she is kept informed. The database generates IC benchmarking for the facility against other Selwyn facilities.

There is a job description for the IC officer including the role and responsibilities. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff are encouraged to have the flu vaccine as noted in the policy.

The service had a norovirus outbreak January 2014. Seven residents and five staff were affected. Measures taken include activities postponed, residents had meals in rooms, all relatives notified, shut down of facility except for essential visitors. Signs were put on all entry/exit doors and alcolgel and notices put beside the doors. All staff and residents were advised of hand hygiene and reminded through the outbreak.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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: FA

Evidence:

The clinical coordinator is the IC officer and IC matters are taken to the staff meeting minutes, and monthly RN forum meeting minutes and reported to the acting facility manager. The IC officer can access external District Health Board IC nurse specialist, laboratories, and general practitioner specialist advice when required – confirmed by the general practitioner interviewed.

The IC officer complies with the objectives of the infection control policy and works with all staff to facilitate the programme. She has attended IC external training with Bug Control in April 2012. Staff complete annual infection control education in 2013 with 23 staff attending. The IC officer has access to all relevant resident information to undertake surveillance, audits and investigations.

The infection control officer contacted the ADHB public health service, the director of nursing at Selwyn and the Health Protection officer for advice in the January 2014 norovirus outbreak – documentation sighted that confirms this.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has infection control policies and an infection control manual which reflect current practise. The outbreak has been updated. The IC programme and job description defines roles and responsibilities of the IC officer. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC officer. The IC programme is reviewed annually by the Selwyn infection control committee and external specialist advice can be accessed if required.
D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections, hand hygiene, standard precautions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The IC officer is an registered nurse – clinical coordinator. She has attended external specialist training in April 2012.

All new staff receive infection control education at orientation including hand washing and preventative measures (confirmed by the registered nurse and five caregivers interviewed).

Annual infection control education was delivered in 2013 and 23 staff attended. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery.

There is evidence of resident and visitor education around influenza and encouragement to have the vaccine.

There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Infection monitoring is the responsibility of the IC officer who is an RN. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the service are appropriate to the acuity, risk and needs of the residents.</p> <p>The IC officer enters infections on to the infection register and data enters infection information into the database, which generates a monthly analysis of the data. The analysis is reported to the staff meeting and monthly RN forum meeting minutes. The IC officer uses the information obtained through the surveillance of data to determine infection control education needs within the facility.</p> <p>Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. The general practitioner confirms that there is notification if there is any resistance to antimicrobial</p>

agents. There is evidence of G.P involvement and laboratory reporting.

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

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

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

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

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

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

