

# Presbyterian Support Southland - Peacehaven

---

Current Status: 28 November 2013

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

## General overview

Peacehaven Village is part of the Presbyterian Support Southland Group (PSS) and provides care across four service levels including; rest home, hospital, and dementia and psychogeriatric level care. There is secure dementia unit made up of two 20 bed units, a dementia secure unit and a psychogeriatric secure unit. There are a total of 117 beds at the facility. On the day of audit there were 19 rest home, 57 hospital level, 20 residents in the dementia unit and 18 residents in the psychogeriatric unit.

The facility is managed by two nurse managers, one for the hospital and rest home part of the facility and the second nurse manager for the secure units.

There is an organisational quality management plan that is implemented at the facility.

This surveillance audit included a review of the 12 aspects of service provision identified in the previous audit as requiring improvement. The service has addressed six of the 12 improvements required. The six areas remaining are around complaints management, risk assessments and some parts of the medication management system. Further areas identified at this surveillance audit as requiring improvement are related to registered nurse cover and staffing in the dementia and psychogeriatric units, service provision timeframes, short term care plans, activities, medication management and nutritional management of residents.

## Audit Summary as at 28 November 2013

Standards have been assessed and summarised below:

### Key

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 28 November 2013

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

### Organisational Management as at 28 November 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

### Continuum of Service Delivery as at 28 November 2013

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

### Safe and Appropriate Environment as at 28 November 2013

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

### Restraint Minimisation and Safe Practice as at 28 November 2013

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

## Infection Prevention and Control as at 28 November 2013

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

---

## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Presbyterian Support Southland
<b>Certificate name:</b>	Peacehaven Village
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand
<b>Types of audit:</b>	Unannounced Surveillance
<b>Premises audited:</b>	498 -500 Tweed Street, Newfield, Invercargill
<b>Services audited:</b>	Rest home, Hospital, Dementia and Psychogeriatric level of care
<b>Dates of audit:</b>	<b>Start date:</b> 28 November 2013 <b>End date:</b> 29 November 2013
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	114

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	14	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	14	<b>Total hours off site</b>	7
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	28	Total audit hours off site	18	Total audit hours	46
Number of residents interviewed	3	Number of staff interviewed	27	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	10	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	190	Number of relatives interviewed	10
Number of residents' records reviewed using tracer methodology	4			Number of GPs interviewed	2

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Thursday, 13 February 2014

## Executive Summary of Audit

### General Overview

Peacehaven Village is part of the Presbyterian Support Southland Group (PSS) and provides care across four service levels including; rest home, hospital, and dementia and psychogeriatric level care. There is secure dementia unit made up of two 20 bed units, a dementia secure unit and a psychogeriatric secure unit. There are a total of 117 beds at the facility. On the day of audit there were 19 rest home, 57 hospital level, 20 residents in the dementia unit and 18 residents in the psychogeriatric unit.

The facility is managed by two nurse managers, one for the hospital and rest home part of the facility and the second nurse manager for the secure units. There is an organisational quality management plan that is implemented at the facility.

This surveillance audit included a review of the 12 aspects of service provision identified in the previous audit as requiring improvement. The service has addressed six of the 12 improvements required. The six areas remaining are around complaints management, risk assessments and some parts of the medication management system. Further areas identified at this surveillance audit as requiring improvement are related to registered nurse cover and staffing in the dementia and psychogeriatric units, service provision timeframes, short term care plans, activities, medication management and nutritional management of residents.

### Outcome 1.1: Consumer Rights

Open disclosure procedures are in place to ensure staff maintain open, transparent communication with residents and their family. Resident files provide evidence communication with family occurs when required.

The Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

There are complaint registers in place and complaint processes are documented and there is evidence of follow up, action and resolution in the hospital / rest home part of the facility, however an improvement is required around managing complaints in the secure units.

There is currently one complaint being investigated by the Ministry of Health.

### Outcome 1.2: Organisational Management

The quality and risk management system is implemented and monitored through the internal audit programme. The key components of the quality management system link to the monthly quality improvement meetings and outcomes are reported to staff, and residents through the various meetings held.

The rest home and hospital and the two secure units (dementia and psychogeriatric) are managed by nurse managers who are both registered nurses. The nurse managers report to the PSS Director of Services for Older People.

There are internal audit programmes to monitor all areas of service delivery. There is a hazard register. Adverse events are documented on accident/incident forms and reviewed by nurse managers. Completed accident/incident forms are retained in individual resident files. Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are developed, implemented and signed off as being completed to address the issues that require improvement.

Meeting minutes evidence reporting on number of various clinical indicators, quality and risk issues, and discussion of any trends identified.

There are policies and procedures on human resources management and the validation of current annual practising certificates for staff that require them is occurring. Staff in-service education sessions are provided and staff are supported to attend external education, as appropriate. Review of staff education records evidence individual education records are maintained.

There is a policy for determining staffing and skill mix for safe service delivery. Rosters sighted evidence adherence to policy and staff skill mix guidelines. The previous areas requiring improvement relating to corrective actions and family notifications of untoward events have been addressed. There is an improvement required around registered nurse cover and staffing in the psychogeriatric and dementia units.

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

Registered nurses are responsible for each stage of service provision. Service delivery plans are individualised. General practitioners conduct three monthly clinical reviews. Residents and family interviewed indicated satisfaction with core aspects of care provided.

Previously identified areas for improvement regarding risk assessments remain.

There are new areas requiring improvement around short-term care plans, risk re assessments, timely referral to specialist services and care plan evaluation.

Activities are provided that reflect ordinary patterns of life and encourage residents to remain integrated in their community. The dementia units focus on activities of daily living. Improvement is required to include individual strategies for de-escalating / diverting strategies in activity plans.

Medication management system is administered by staff that have completed annual medication competencies. There are no residents self-administering medicines at the facility.

There continues to be improvements required around medication management.

Residents have a nutritional assessment completed on admission and dietary requirements with likes and dislikes are recorded.

There are improvements required around implementing dietitian advice and residents fluid intakes.

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

The facility building warrant of fitness was sighted as current. Improvement required by a previous audit regarding water temperatures and monitoring has been implemented and an improvement made.

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

The restraint minimisation policy includes definitions of restraint and enabler that is congruent with the definition in standard. The service has a restraint co-ordinator who is the physiotherapist and a job description is available. The service has a restraint register which includes the type of restraint, date commenced and comments.

The previous areas requiring improvement around enablers and monitoring requirements have been addressed.



### Outcome 3: Infection Prevention and Control

Peacehaven has an established infection control programme appropriate for the size, complexity, and degree of risk associated with the service. Infection control is linked into the quality system. The infection control coordinator is responsible for on-going education of staff and residents at Peacehaven. Surveillance for infection is part of the infection control programme and is described in infection control policy. Monthly infection data is collected on all infections. This data is monitored and outcomes discussed at the infection control meetings. Surveillance links to an external benchmarking programme.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	11	0	3	5	0	0
<b>Criteria</b>	0	36	0	3	4	1	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	31
<b>Criteria</b>	0	0	0	0	0	0	0	57

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	There is evidence of the complaints management process not being followed for complaints lodged with the dementia service part of the	Provide evidence complaints in the dementia units are managed, as per policy and the Code of Rights.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				facility.		
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	ARHSS D17.3; there is not a rostered registered nurse across 24/7 in the PG unit. D17.4a;	As per the ARHSS contract D17.3 ensure a registered nurse is rostered in the PG unit across 24/7.	30
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA High	A psychogeriatric resident had delayed response to referral to specialist services for management of a deteriorating pressure injury and decreased mobility. The resident did not have care or review of a supra-pubic catheter documented for seven months and fluid intake for the seven days prior to audit did not document an accepted level of intake with no	Improvement is required to ensure: a) review of health status changes take place in a timeframe relevant to the a change in status to ensure timely response to changes and issues; b) routine evaluations take place within the timeframes required in policy and monitoring frequency reflects risk level; c) all possible causes of a decline are considered; d) timely referral to	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>documented or verbal report to alert staff to the need for an immediate response. There was delay in communicating to family the resident decline in health status or involvement in care planning.</p> <p>Two of four resident files receiving hospital level care were overdue for their November evaluation.</p> <p>There was no evidence of one psychogeriatric resident with on-going weight loss having an evaluation of care or referral to a dietitian in response to the on-going weight loss. Weight monitoring remained at monthly.</p> <p>Five residents of the dementia unit's fluid balance chart records documented fluid intake level of below 1100mls per 24 hours for the previous seven days. Short term care plans for urinary tract infection required only three days of fluid balance chart to monitor fluid intake.</p>	<p>specialist services, e) all care plan and specialist requirements are implemented; f) resident requests are considered in a timely manner; g) documentation accurately reflects the provision of care or reason why care was not actioned as instructed. h) Timely completion of care provision.</p>	

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>A hospital level resident had a delay in reviewing possible causes for mobility decline.</p> <p>A rest home level care resident did not have a dietitian recommended plan fully implemented and there was no documentation regarding a reported decline of a high protein drink offered. A request by the resident to be seen by the service dietitian did not take place in a timely manner.</p> <p>Family interviews stated residents in the psychogeriatric unit were observed to be left during the provision of cares for staff to attend to other residents such as being placed on a toilet and left for an extended period before being assisted to be removed.</p>		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes,	PA Moderate	Not all possible care	Improvement is	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.		needs are routinely reassessed when they have not previously been identified. (i) Pain assessment tools were not utilised for two residents reviewed (one psychogeriatric and hospital level care) who received pain relief regularly. (ii) The five residents who did not have pain identified previously did not include reassessment during the review process. (iii) Two of six files reviewed that had identified high falls risk on assessment did not include a completed falls prevention strategies form. (iv) Three of seven files reviewed did not include a continence reassessment. (v) Two of four dementia residents did not include behaviour assessment.	required to ensure all possible care needs are reassessed routinely.	
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or	PA Low	No short-term care plan or inclusion in	Improvement is required to ensure all	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		long term care plan was sighted for one resident with a current urinary tract infection and two residents with weight loss.	interventions required are documented on a short or long term care plan to ensure staff are aware of all aspects of care to be implemented.	
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Activity plans do not include de-escalating/diverting strategies that reflect the resident past activities or are identified as assisting the individual resident.	Improvement is required to ensure activity plans identify individual strategies for de-escalating / diverting strategies.	180
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and	PA Moderate	(i)Two of three residents receiving controlled drugs the time stated in the controlled drug register differed from that stated in the administration signing sheet. (ii)There is no	Improvement is required to: (i) the times stated in the controlled drug register reflect the time the controlled drug was administered; (ii) complete six monthly	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>quantitative balance completed at least six monthly. (iii) The house G.P. used } to group sign medications on seven of 14 charts reviewed. (iv) Two of 14 charts reviewed did not state allergies or none known. (v) Six of 14 charts the PRN medications did not include indications of use for all PRN medications charted</p>	<p>controlled drug stocktakes; (iii) ensure all medication instructions are individually signed by the prescribing G,P.; (iv) PRN instructions include indication of use; and (v) all medication charts state allergies or none known.</p>	
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.13.2	Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Moderate	(i)A residents dietitian recommendations were not documented as actioned. (ii) Five residents fluid balance charts for the seven previous days were reviewed; the highest total fluid intake for any resident was 1100 mils in a 24 hour period.	(i)Ensure residents with nutritional recommendations are communicated to the kitchen; (ii) a plan for addressing any short-fall in fluid intake be documented and implemented.	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 1.1.9: Communication (HDS(C)S.2008:1.1.9)

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

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

**Attainment and Risk:** FA

#### Evidence:

Residents interviewed (three rest home and one hospital) state they are informed regarding their care and treatment, staff communicate well with them and are aware of the staff who are responsible for their care. Family interviews were conducted with five hospital and three psychogeriatric (PG) and two dementia family members. Nine of 10 family interviews state they are informed regarding their family member's care and any change in residents' wellbeing (refer to CAR 1.3.3.3 re interview with PG family member).

There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms and progress notes and confirmed at GP interviews.

Residents' meetings occur bi monthly in the hospital / rest home part of the facility, sighted minutes of meetings for 2013. Family meetings are held in the secure units and minutes for 2013 were sighted for April and October 2013. Family interviews with two of two dementia family members confirm attendance at the family meetings.

The information pack and the admission agreement include payment for items not included in the services. Sighted information pack specific for the secure units and this includes specific welcome to dementia unit residents and family members, including Presbyterian Support Southland Charter; including vision and core values, restraint and behaviour management. Alzheimers New Zealand information pamphlet on dementia and contact for Alzheimers Southland Community Service Worker is included in the admission pack.

Interview with the facility's past chaplain, who is now employed as an advocate and co-ordinates family and resident surveys was conducted. The advocate states the 2013 resident and family survey is being completed.

Related ARC and ARHSS contract requirements are met.

**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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> There is a complaints, concerns and suggestions policy, that complies with Right 10 of the Code. Residents and their family are provided with information on the complaints process on admission and complaint forms are displayed at entrance to the facility. The complaint process is in a format that is readily

understood.

Staff are aware of the complaints process and who they should direct complaints to, confirmed at staff interviews. Residents and family confirm that they understand the complaints process and that they know how to access advocacy services.

There are two complaints registers at the facility - one pertaining to the hospital / rest home part of the facility and second one to the secure units. Both complaint registers were reviewed.

The hospital / rest home complaints register was reviewed with the hospital / rest home nurse manager and evidences one 'verbal concerns' register and second register for written complaints for this area. The verbal concerns register evidences 36 verbal complaints for 2013, which are all closed. The verbal concerns register records the complainant's name; date; details of the nurse manager's resolution and nurse manager's signature.

The written complaints register for hospital / rest home evidences 18 written complaints for 2013. The complaints register details the name of the complainant; resident's name; date; type of complaint; date of first letter sent (within 5 days of complaint); date of second letter sent, if this is required and any meetings conducted and date of resolution. All complaints sighted were all closed off and followed the complaints policy and Health & Disability Code of Rights timeframes. There is evidence of supporting documents with the complaints, including (but not limited to); investigations and follow up letters. Complaints records and hospital / rest home nurse manager interview demonstrate that complaints in the hospital and rest home are actively managed.

The secure units complaints register was reviewed with the dementia nurse manager and evidences there are 12 complaints registered (one verbal and 11 written) and of the 12 complaints there are five complaints outstanding and the complaints process has not been followed according to policy and The Code and this requires an improvement.

The hospital / rest home nurse manager advises there have been no complaints investigated by the Health and Disability Commissioner, DHB, Coroner, ACC since the previous audit at this facility, however there is one complaint being investigated by the Ministry of Health. This complaint was received from HealthCERT regarding a resident receiving wrong medication in the dementia unit.

Interview with the hospital / rest home nurse manager states this investigation is in process and being investigated by the hospital /rest home nurse manager, as the director is on annual leave till December 2013.

The previous area requiring improvement around the complaints register not being consistently recording closure/resolution of complaints remains open.

Related ARC and ARHSS contract requirements are not fully met.

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>The hospital / rest home complaints register evidences all complaints are closed off and the complaints policy and timeframes are adhered to. The dementia unit's complaints register evidences outstanding complaints and the complaints management process not adhering to policy.</p> <p>Examples of complaints reviewed for October and November 2013;</p> <p>1) The dementia unit nurse manager states the complaint dated 8/10/13 (regarding other resident's behaviour) was referred to the director and a letter of acknowledgement was sent from the director, however this letter is not located on file and there is no further notification to the complainant of the investigation recorded.</p> <p>2) Complaint dated 30/10/13, (complaint regarding resident's care) evidences this complaint has not been acknowledged in writing, as per policy. The dementia unit nurse manager states a phone conversation was held with the complainant, however this is not recorded.</p> <p>3) Complaint dated 2/11/13 (behaviour of other resident) evidences this complaint has not been acknowledged in writing, as per policy.</p>
<p><b>Finding:</b></p> <p>There is evidence of the complaints management process not being followed for complaints lodged with the dementia service part of the facility.</p>
<p><b>Corrective Action:</b></p> <p>Provide evidence complaints in the dementia units are managed, as per policy and the Code of Rights.</p>
<p><b>Timeframe (days):</b> 30     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>

**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:**

The governing body, Presbyterian Support Southland (PSS) has established systems in place, which define the scope, direction and goals of the organisation and the monitoring and reporting processes against these systems. The quality monitoring programme monitors contractual and standards compliance and the quality of service delivery in the facility.

Peacehaven is a purpose built facility, that is part of a wider village. It provides care for up to 117 residents requiring hospital level of care (geriatric and medical), rest home level care, dementia level of care and psychogeriatric level of care (PG). The residential care rooms (77 beds) include rest home and hospital rooms. The secure units are made up of two separate 20 bed units, a residential level dementia secure unit and a specialised hospital level secure unit (PG) and the residents are cared for in the two distinct secure units. On the first day of the audit, there were 57 hospital residents, 19 rest home residents, 20 residents in the dementia unit and 18 residents in the psychogeriatric unit (PG).

There are two nurse managers at the facility, one for the residential (hospital / rest home) area of the facility and one for the dementia units. Both nurse managers report directly to the PSS Director for Older People. There are documented responsibilities for the nurse managers including reporting requirements and nurse manager's job descriptions, sighted. Both nurse managers' personal files are located at PSS head office and could not be reviewed at audit.

The hospital /rest home nurse manager is a registered nurse with current practising certificate (sighted) and has been managing this part of the facility, including the non clinical services, such as the cleaning, laundry and kitchen for approximately two years. Previous to this appointment the hospital /rest home nurse manager states she was in a position of a clinical co-ordinator at a residential care facility for 2 years and prior to that in a position of aged care service co-ordinator at DHB. This hospital / rest home nurse manager is also in the role of quality improvement co-ordinator and a temporary clinical co-ordinator for the hospital /rest home. The position of the hospital / rest home clinical co-ordinator is being advertised.

The nurse manager (RN) in the secure units has been in this position for 6 years and holds a current practising certificate and states prior to this has been in a position as head of department in a dementia unit at another residential care facility. Dementia unit clinical co-ordinator (RN) has been working as an RN in this unit for 3 years and in this role for eight months.

Interviews of both nurse managers, indicate they have undertaken training in relevant areas to their positions. Support for the nurse managers is provided by Presbyterian Support Southland head office.

The related ARC and ARHSS contract requirements are met.

**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.

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Presbyterian Support Southland ( PSS) Board consists of a Chief Executive and an Executive Management Team. The two nurse managers report to the

PSS Director Services for Older People. Strategic plan (January 2010 to December 2013) was sighted and records five principles of quality service with related objectives and measurements. There are infection control, health and safety and quality goals, related strategies and initiatives and these are displayed at the facility.

Presbyterian Support Southland, Services for Older People, Quality Improvement plan was sighted (reviewed October 2013) and includes quality objectives, aims and strategies in quality improvement programme. The quality improvement committee meets monthly and this is a combined meeting for the whole facility and is chaired by the quality improvement co-ordinator (the hospital /rest home nurse manager) and there is representation from all areas of the service, such as health and safety, maintenance, infection control, restraint, kitchen. Sighted terms of reference for the quality improvement committee and meeting minutes for 2013.

Completed internal audits for 2013, incidents/ accidents forms were reviewed along with clinical indicators for 2013 for the two areas of the facility. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting quality and risk issues, and discussion of any trends identified in the monthly quality improvement meetings and at staff meetings. An external benchmarking programme (QPS) is in place and includes monitoring of key performance indicators. Benchmarking reports were sighted and include reports and benchmarking on care staff work hours; manual handling injuries; pressure injuries; customer complaints; skin tears; resident falls; wound infections; skin infections. The quality and the QPS data trends are identified and evaluated.

The secure units nurse manager and hospital / rest home nurse manager interviews confirm there are separate internal audit schedules that are completed for the two areas and the audit results are communicated to staff. There are also separate staff meetings in these two areas and family meetings for the dementia units, sighted.

Staff interviewed (10 care workers working morning and afternoon shifts in the hospital / rest home, two care workers in dementia unit, six RN's (five in rest home / hospital and one in dementia), four ENs and dementia clinical co-ordinator) report they are kept well informed of quality and risk management issues including clinical indicators.

There is a Hazard reporting system available and a Hazard Register. Chemical safety data sheets available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place.

Area requiring improvement around corrective actions from previous audit is now fully met.

Related ARC and ARHSS contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

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

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

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



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

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

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

**Criterion 1.2.3.6 (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.

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

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

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

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

**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 adverse event reporting system evidences a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form, which are then filed in resident files. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.

There is evidence of analysis of this data for trends reviewed in meeting minutes and confirmed during interviews of staff. Staff can describe the incident reporting process and their role. The service identifies and reports appropriate situations to statutory authorities such as infectious diseases, serious harm, unexpected death and other situations relevant to this type of service to the MoH. There is an open disclosure policy and family are informed of incidents. A review of incident/accident forms (10 hospital / rest home, 12 dementia) identified that all were fully completed and included follow-up.

Resident files reviewed provide documented evidence of communication with family and GP on the 'Incident/Accident Form', and in resident progress notes. Evidence also reviewed during this audit of notification to family of any change in the residents condition of nine of ten family interviewed (refer to CAR 1.3.3.3, interview with PG family member).

Previous area requiring improvement around documentation of incident forms is now fully met (also link 1.1.9).

### 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Review of the 2013 in-service education plan and staff education records provide evidence in -service education is conducted at the facility. The dementia nurse manager states the staff employed in the dementia units have completed the required dementia training or are in the process of completing training, confirmed at review of staff files.</p> <p>A review of 10 staff records (six from hospital / rest home and four from dementia unit) provide evidence human resource processes are followed and are completed. There are job descriptions available for all relevant positions and staff have employment contracts. An appraisal schedule is in place and current staff appraisals were sighted for both areas of the facility. Annual practising certificates are current for all staff that require them to practice, sighted. Staff interviewed confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Hospital / rest home nurse manager states that registered staff from hospital / rest home part of the facility are also orientated to the dementia units.</p> <p>The related ARC and ARHSS contract requirements are met.</p>

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

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

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

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

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

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

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

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

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Determining staffing levels and skills mix policy is documented. Data on care staff work hours is collected for Quality Performance Systems Benchmarking. Residents' care requirements are divided into four areas within the hospital and rest home facility and two areas in the secure unit.

There are two nurse managers employed at Peacehaven, one for the hospital and rest home residents and one for the dementia and psychogeriatric residents. One clinical co-ordinator is employed in the dementia / psychogeriatric unit and there is a vacancy for a clinical co-ordinator in the rest home / hospital part of the facility. The hospital / rest home nurse manager is assigned to this position until this position is filled. There are 15 RNs and eight ENs employed at the facility. Eleven RNs and six ENs for the hospital and rest home area and four RNs and two ENs for the dementia units.

Registered nurse cover at the facility is provided 24 hours a day.

Care workers (10) in the hospital /rest home interviewed report that there is enough staff on duty and they are able to get through the work allocated to them and state they work well as a team to provide assistance to each other. Hospital and rest home residents interviewed report there is enough staff on

duty to provide them with adequate care.

Hospital /rest home roster evidences;

Hospital /rest home nurse manager is employed Monday to Friday each week and currently also fills in the position of the clinical co-ordinator.

There are four areas of the hospital /rest home facility and rosters evidence each area has either RN or EN and four care workers on morning shift and RN or EN and three care workers on afternoon shift and on night shift there is one RN and four care workers.

The nurse manager states the senior registered staff member who is the Duty Leader in afternoons after 1700 hours and in the weekends and the night RN are responsible for maintaining communication with and support dementia staff and monitoring dementia residents' cares when the dementia unit does not have a Registered Nurse rostered on duty.

Dementia unit roster evidences the dementia nurse manager is employed Monday to Friday each week on the dementia roster, however oversees the management of both the dementia and PG units.

The clinical co-ordinator is employed Monday to Friday each week on the roster and oversees the clinical care for both the dementia and PG units.

Dementia roster evidences additional staff to the dementia nurse manager and the clinical co-ordinator on morning shift as;

Diversional therapist; Monday to Friday from 0900am to 1730pm.

Duty leader; (RN/ EN/or senior careworker) 0700am to 1530pm 7 days a week.

There are two care workers employed from 0700-1500.

The afternoon shift on dementia unit is covered by;

Two careworkers from 1500 hrs to 2300 hrs. and additional one activities person from 1700 to 2100 hrs on Mondays to Friday and 1600 to 2100 hrs on Saturday and Sundays. Family interviews (2) from the dementia unit state there appears not to be enough staff on afternoon shifts in the dementia unit.

PG roster evidences additional staff to the dementia nurse manager and the clinical co-ordinator on morning shift as;

RN or EN from 0650 – 1520 hrs Monday to Sunday.

Two care workers from 0700 to 1500 hrs and one activities /care worker from 0700 to 1330 hrs Monday to Sunday. One care worker from 0800 to 1000 am from Monday to Friday.

On afternoon shift there is one RN or EN from 1510 to 2310 hrs and one care worker from 1500 to 2300; one careworker from 1530 to 2400 hrs and one care worker/ activities from 1700 to 2100 hrs.

On night shift there is one RN or EN from 2300 to 0700 hrs; two careworkers from 2400 to 0800 hrs (shared with the dementia unit).

Dementia nurse manager states when there is an EN on in the unit, there is access to RN in the hospital and rest home wing of the facility. The on call system is communicated to staff and staff state they are aware of who is the on call person.

There is an improvement required around RN cover (as per ARHSS D17.3 b) in the dementia and psychogeriatric units.

Family interviews stated residents in the psychogeriatric unit were observed to be left during the provision of cares for staff to attend to other residents such as being placed on a toilet and left for an extended period before being assisted to be removed (refer to CAR 1.3.3.3).

### 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:** PA Moderate

**Evidence:**

PG roster evidences additional staff to the dementia nurse manager and the clinical co-ordinator on morning shift as; RN or EN from 0650 – 1520 hrs Monday to Sunday.  
Two care workers from 0700 to 1500 hrs and one activities /care worker from 0700 to 1330 hrs Monday to Sunday. One care worker from 0800 to 1000 am from Monday to Friday.  
On afternoon shift there is one RN or EN from 1510 to 2310 hrs and one care worker from 1500 to 2300; one careworker from 1530 to 2400 hrs and one care worker/ activities from 1700 to 2100 hrs.  
On night shift there is one RN or EN from 2300 to 0700 hrs; plus two careworkers from 2400 to 0800 hrs across the two units.  
Dementia nurse manager states when there is an EN on in the unit, there is access to RN in the hospital and rest home wing of the facility. The on call system is communicated to staff and staff state they are aware of who is the on call person.  
Family interviews stated residents in the psychogeriatric unit were observed to be left during the provision of cares for staff to attend to other residents such as being placed on a toilet and left for an extended period before being assisted to be removed (refer to CAR 1.3.3.3).

**Finding:**

ARHSS D17.3; there is not a rostered registered nurse across 24/7 in the PG unit. D17.4a;

**Corrective Action:**

As per the ARHSS contract D17.3 ensure a registered nurse is rostered in the PG unit across 24/7.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The registered nurses at Peacehaven are responsible for development of the care plan with input from the care workers and Diversional Therapy (DT) /activity staff. The two GPs interviewed stated they were asked for medical input and guidance.



The initial assessment also forms the initial care plan and was developed within 24 hours of admission on seven of the seven files reviewed. The assessment and support plan includes; elimination, nutrition, hydration, sleep, hygiene and grooming, mobility and exercise, social and behavioural, sensory, cultural and spiritual, pain, plus additional headings according to need.

Up until August 2013, the seven files reviewed documented RN evaluations completed four to six weekly, however the dementia clinical coordinator stated there had been a policy change to requiring RN evaluation three monthly for hospital level care residents and six monthly for rest home level care residents. Two of four resident files receiving hospital level care were overdue for their November evaluation.

Continuing assessments are completed within three weeks of admission and the long-term care plan is developed within three weeks. Assessments include pressure area risk, falls risk, nutrition, pain, behaviour, mobility, medical history and continence. Also social history is completed by the DT/activity staff. Refer to CAR 1.3.4.2.

Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the care plan, however one family reported a lack of communication in a timely manner regarding their residents decline in health status. There is a form for documenting communication concerning care planning with family; five of seven files reviewed this form-documented contact in line with the last care plan review. Two (one PG and one dementia) did not.

Interviews with staff described a verbal and written handover process at the end of each shift and between the team leaders and management staff; this was observed to take place in the secure units. There is also a communication book. Staff are informed of any care plans that have been updated at handover.

Progress notes are written at the end of each shift with separate reporting sections for caregiver and registered nurse staff. Any issues arising from quality meetings and resident meetings are communicated to staff. The registered nurses inform staff of any changes to residents' care following visits from the general practitioner or other allied healthcare personnel and also document this information in RN residents' progress notes and care plans. Seven of seven resident files (two dementia, two psychogeriatric, one rest home and two hospital) identify integration of allied health personnel and a team approach is evident.

Input from a number of allied health personnel is evident in all seven files reviewed including physiotherapist, activity staff, podiatrist, wound specialist and dietitian.

D16.2, 3, and 4: Seven of seven files reviewed identified that an assessment was completed within 24 hours by a registered nurse.

D16.5e: Seven of seven resident files reviewed identified that the general practitioner had seen the resident within two working days of admission with monthly, three monthly and as needed reviews according to stability of health status.

Three monthly medication reviews by a general practitioner are documented on the medication prescribing chart of 14 of 14 residents' files reviewed. A support plan is developed within three weeks of admission and is signed and dated by the allocated registered nurse.

Two GP interviews advised that the staff are prompt to notify them of changes in health status of residents and that medical care instructions are implemented.

ARHSS D16.6; Behaviour strategies for resident with identified challenging behaviour are detailed and behaviour monitoring charts are used to identify behaviours and strategies that assisted (refer to CAR 1.3.7.1). Of note was the new behaviour management strategies tool currently being implemented in the psychogeriatric and dementia units, which detailed a range of strategies to address individual behaviours. Observation of the facility during the audit identified a calm quiet environment including in the dementia units.

Tracer methodology psychogeriatric resident.

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

Tracer methodology: dementia resident.

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

Tracer methodology hospital level care resident.

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

Tracer methodology rest home level care resident.

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

Improvement is required to ensure: a) review of health status changes take place in a timeframe relevant to the a change in status to ensure timely response to changes and issues; b) routine evaluations take place within the timeframes required in policy and monitoring timeframes reflect risk level; c) all possible causes of a decline are considered; d) timely referral to specialist services, e) all care plan and specialist requirements are implemented; f) resident requests are considered in a timely manner; g) documentation accurately reflects the provision of care or reason why care was not actioned as instructed.

**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.

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

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

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

**Attainment and Risk:** PA High

#### **Evidence:**

Up until August 2013 the seven files reviewed documented RN evaluations completed four to six weekly, however the dementia clinical coordinator stated there had been a policy change to requiring RN evaluation three monthly for hospital level care residents and six monthly for rest home level care residents. Two of four resident files receiving hospital level care were overdue for their November evaluation.

There is a folder containing all forms to be completed to evidence monitoring of residents contained the fluid balance charts in each unit. Five residents in the dementia units fluid balance charts for the seven previous days were reviewed; the highest total fluid intake for any resident was 1100 mls in a 24 hour period.

There were no recorded alerts and staff spoken to do not report receiving instruction to address these low fluid intakes. The dementia clinical co-ordinator reported frequent reminders to caregivers to ensure fluid intake was charted and residents received an adequate intake.

Two monitoring folders reviewed for the hospital and rest home level care residents identified only two residents are currently on fluid balance charts. Their documented intake was adequate. Short term care plans addressing urinary tract infections are in place for the three days of antibiotic treatment only.

A hospital level care resident had a decline in mobility resulting in a pressure injury. A wound care management plan and record of dressings were sighted. The mobility decline was subsequently attributed to a change in medication and upon re-instatement of the medicine an improvement was noted in mobility and improvement in the pressure injury. On interview with family it was stated there was some concern regarding the time taken to identify the decline and review the resident. There was a recorded RN evaluation documenting the decline in mobility but no indication of consideration as to why. It was stated that the nurse manager implemented a review and action.

A rest home level care resident returned from hospital admission with a dietitian report documenting weight loss and a recommended nutritional plan. The resident stated on interview that they had been requesting to see a dietitian since return from hospital, the nurse manager stated the resident had been seen by a dietitian on the day of the audit however when interviewed at the end of the second day of audit the resident they were still waiting to see a dietitian.

Family interviews stated residents in the psychogeriatric unit were observed to be left during the provision of cares for staff to attend to other residents such as being placed on a toilet and left for an extended period before being assisted to be removed.

#### **Finding:**

A psychogeriatric resident had delayed response to referral to specialist services for management of a deteriorating pressure injury and decreased mobility. The resident did not have care or review of a supra-pubic catheter documented for seven months and fluid intake for the seven days prior to audit did not document an accepted level of intake with no documented or verbal report to alert staff to the need for an immediate response. There was delay in communicating to family the resident decline in health status or involvement in care planning.

Two of four resident files receiving hospital level care were overdue for their November evaluation.

There was no evidence of one psychogeriatric resident with on-going weight loss having an evaluation of care or referral to a dietitian in response to the on-going weight loss. Weight monitoring remained at monthly.

Five residents of the dementia unit's fluid balance chart records documented fluid intake level of below 1100mls per 24 hours for the previous seven days.

Short term care plans for urinary tract infection required only three days of fluid balance chart to monitor fluid intake.

A hospital level resident had a delay in reviewing possible causes for mobility decline.

A rest home level care resident did not have a dietitian recommended plan fully implemented and there was no documentation regarding a reported

decline of a high protein drink offered. A request by the resident to be seen by the service dietitian did not take place in a timely manner. Family interviews stated residents in the psychogeriatric unit were observed to be left during the provision of cares for staff to attend to other residents such as being placed on a toilet and left for an extended period before being assisted to be removed.

**Corrective Action:**

Improvement is required to ensure: a) review of health status changes take place in a timeframe relevant to the a change in status to ensure timely response to changes and issues; b) routine evaluations take place within the timeframes required in policy and monitoring frequency reflects risk level; c) all possible causes of a decline are considered; d) timely referral to specialist services, e) all care plan and specialist requirements are implemented; f) resident requests are considered in a timely manner; g) documentation accurately reflects the provision of care or reason why care was not actioned as instructed. h) Timely completion of care provision.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Standard 1.3.4: 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 Moderate

**Evidence:**

At last certification audit there were two areas identified requiring improvement ( criteria 1.3.4.1 and 1.3.4.2) to ensure assessments and management plans are completed to ensure effective support planning. This finding remains a requirement.

Seven resident files were reviewed (two psychogeriatric, two dementia rest home, two hospital and one rest home level care)

The initial comprehensive nursing assessment is completed within 24 hours of admission. Assessments and support plans are detailed and include input

from a general practitioner, support services and medical specialists as appropriate. A range of assessment tools were evidenced in resident files on admission and are reviewed three to six monthly including: falls risk assessment, Waterlow pressure area risk assessment, continence assessment, pain assessment, challenging behaviour assessments and a mini nutritional assessment. Ten family members and four residents interviewed are satisfied with the support provided. Improvements are required in the documentation of assessment and reassessment of all possible care needs. ARC E4.2; ARHSS D16.5gii four resident files (two rest home dementia and two psychogeriatric) reviewed included an individual assessment that included identifying motivation and recreational requirements. E4,2a Challenging behaviours assessments are completed if there is an identified issue. The new behaviour management strategies tool currently being implemented in the psychogeriatric and dementia units, which detailed a range of strategies to address challenging individual behaviours. Refer CAR 1.3.7.1.

**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.

<p><b>Attainment and Risk:</b> PA Moderate</p>
<p><b>Evidence:</b></p> <p>Seven resident files were reviewed (two psychogeriatric, two dementia rest home, two hospital and one rest home level care).</p> <p>The service undertakes an initial assessment within 24 hours of admission and uses a range of assessment tools to develop the long term support plan. Risk assessment tools and monitoring forms are available and implemented including (but not limited to); ‘Waterlow’, falls assessment, pain assessment, continence assessment, mini nutritional, and challenging behaviour.</p> <p>Pain assessment tools were not utilised for two residents reviewed (one psychogeriatric and one hospital level care) who received pain relief regularly. The five residents who did not have pain identified previously did not include reassessment during the review process, one registered nurse evaluation statement did include that pain was not a current issue.</p> <p>Two of six files reviewed that had identified high falls risk on assessment did not include a completed falls prevention strategies form.</p> <p>Three of seven files reviewed did not include a continence reassessment. Two of four dementia residents did not include challenging behaviour assessments.</p> <p>The dementia clinical co-ordinator reported that three staff had completed their InterRAI training and more were booked to commence. The intent of the facility is to introduce the use of InterRAI assessment tool during 2014.</p> <p>Seven of seven files reviewed had evidence of input from external expertise such as wound nurse, physiotherapist, podiatrist, and dietician.</p>
<p><b>Finding:</b></p> <p>Not all possible care needs are routinely reassessed when they have not previously been identified. (i) Pain assessment tools were not utilised for two residents reviewed (one psychogeriatric and hospital level care) who received pain relief regularly. (ii) The five residents who did not have pain identified previously did not include reassessment during the review process. (iii) Two of six files reviewed that had identified high falls risk on assessment did not include a completed falls prevention strategies form. (iv) Three of seven files reviewed did not include a continence reassessment. (v) Two of four dementia residents did not include behaviour assessment.</p>
<p><b>Corrective Action:</b></p> <p>Improvement is required to ensure all possible care needs are reassessed routinely.</p>

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

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

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

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

**Attainment and Risk:** PA Low

#### **Evidence:**

Seven resident files were reviewed (two psychogeriatric, two dementia rest home, two hospital and one rest home level care). Support plans include: hygiene and grooming, mobility, nutrition/fluids, skin and pressure area care, elimination, emotional well-being, loneliness, behaviour, rest and sleep, communication, spirituality, faith and culture, and medical plus additional headings according to need. The registered nurse evaluation of each care requirement detailed the implementation of the care and response. Of note was the new behaviour management strategies tool currently being implemented in the psychogeriatric and dementia units, which detailed a range of strategies to address individual behaviours. Observation of the facility during the audit identified a calm quiet environment including in the dementia units.

Discussions with two GPs, ten careworkers, six registered nurses, four enrolled nurses, one dementia clinical co-ordinator, two nurse managers, four residents (three rest home and one hospital) and ten family members (five hospital, three psychogeriatric and two dementia) identified a satisfaction with the care provided. It was commented by a number that staff in the dementia units, were observed to be very busy and it was difficult to ensure that more than residents basic care needs were met. Family interviews stated residents in the psychogeriatric unit were observed to be left during the provision of cares for staff to attend to other residents such as being placed on a toilet and left for an extended period before being assisted to be removed (refer to CAR 1.2.8.1 and 1.3.3.3).

Short-term care plans are used for acute or short-term changes in health status and were sighted in use for all current wounds and a resident with current urinary tract infection in the hospital unit. Past short-term care plans were sighted on three files. No short-term care plan or inclusion in long term care plan was sighted for one resident with a current urinary tract infection and two residents with weight loss.

There is evidence of referrals to specialist services such as psychiatric services for the elderly, needs assessment, wound care specialist, dietician, physiotherapist, and podiatry. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by the registered nurse. Care plans are goal oriented and reviewed at least six monthly for rest home residents including dementia and three monthly for hospital residents including psychogeriatric (refer to Car 1.3.3.3).

During the tour of facility it was noted that all staff treated residents with respect and were friendly and welcoming to family, which was confirmed at interview with residents, and families.

There is a programme of activities in place and residents are able to access the community and associated services and support.

Continence products are available and resident files include a urinary continence assessment if the resident is known to have a continence issue, bowel management, and continence products identified for day use, night use, and other management (refer to CAR 1.3.4.2).

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use in the main hospital area, which the dementia unit's stock mobile wound trolleys from.

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

There are currently nine residents receiving wound care, four of these residents have either three or four sites being dressed. Five residents had been referred to special wound care services with four seen and one referral in process. The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

ARHSS D16.4; There is good specialist input into residents in the PG unit via referral for psychiatric services for the elderly. Strategies for the provisions of a low stimulus environment could be described. The facility has a focus on reducing use of antipsychotic medicines; review of medication system identified only one resident was recently administered PRN antipsychotic medication.

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Short-term care plans are used for acute or short-term changes in health status and were sighted in use for all current wounds and a resident with current urinary tract infection in the hospital unit. Past short-term care plans were sighted on three files. No short-term care plan or inclusion in long term care plan was sighted for one resident with a current urinary tract infection and two residents with weight loss, progress notes and staff interviews confirmed knowledge of the requirements.
<b>Finding:</b> No short-term care plan or inclusion in long term care plan was sighted for one resident with a current urinary tract infection and two residents with weight loss.
<b>Corrective Action:</b> Improvement is required to ensure all interventions required are documented on a short or long term care plan to ensure staff are aware of all aspects of care to be implemented.
<b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** PA Low

### Evidence:

On admission the activity staff (hospital / rest home area) and the diversional therapist (psychogeriatric and dementia) complete an activity social profile documenting resident's social history, likes and dislikes and past and present interests. The individual activity plan is completed within three weeks.

Seven resident files reviewed (two psychogeriatric, two dementia, one rest home and two hospital) contained an assessment and activity support plan.

Seven of seven resident files reviewed identified that the individual activity plan is reviewed in line with care plan review

The facility employs four activities co-ordinators who work in the rest home/hospital providing an activity programme five days per week. The residents receive a printed copy of the weekly programme. Copies of the programme are also displayed on the notices boards. The programme includes group activities that include resident preferences expressed at resident meetings and identified in the resident's individual profile such as quizzes, beauty therapy, one to one activities, outings, church services, visiting entertainment, movie nights, gardening, bowls, reminiscing, crafts, music and a variety of activities to maintain strength and interests. Participation in activities is voluntary. A record of attendance is maintained and evaluation of the programme content takes into account numbers attending. Residents unable to participate in a group activity are involved by watching and one to one time is provided to those who remain in their bedrooms. Outings are regularly provided.

The two activities staff interviewed are currently completing dementia and diversional therapy papers. They do not take part in the multi-disciplinary reviews, but described contributing input via the registered nurses. Progress notes are written for each resident. Four residents and five family (hospital / rest home) interviewed expressed a satisfaction with the programme.

A qualified diversional therapist (DT), who also acts as team leader, oversees the activity programme in the Iona Wing (dementia rest home and psychogeriatric unit). There are activity staff, that support the provision of group and individual activities seven days per week. The DT explained that the philosophy of the unit involves all staff being a part of activities of daily living and it is promoted that it is the resident's home and their routines are supported. There is a lifestyle/personal history and assessment completed and an activity plan is developed and reviewed at least six monthly. The group activities include a variety of activities that reflect normal patterns of life including church services and entertainers. For these activities the DT described one event takes place and residents from both units attend with staff supervision. The door between the units remains open for the duration of the event to allow residents to freely return to their units, as they wish. Observation of the connecting doors during audit identified that they remained closed and there was separation of the resident level of care.

Families interviewed (three from psychogeriatric and two dementia rest home) indicate resident participate in activities as able and staff are very good at attempting to engage the residents.

ARHSS 16.5g.iv: Caregivers were observed throughout the audit involved in providing one-to-one activity. There was no evidence of a resident requiring diverting from behaviours observed.

There is a generic list of de-escalating/diverting strategies of which resources are available 24 hour per day for staff to implement as they assess required. Individual activity plans do not include identification of such strategies, that reflect the individual residents past activities or that are identified as assisting in diverting the individual resident. There is no indication of which strategies have been successful in the past unless the resident has a behaviour monitoring chart in place.



### 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:** PA Low

**Evidence:**

There is a generic list of de-escalating/diverting strategies of which resources are available 24 hour per day for staff to implement as they assess required. Individual activity plans do not include identification of such strategies that reflect the residents past activities or that are identified as assisting in diverting that individual resident. There is reported evaluation of which strategies have been successful in the past unless the resident has a behaviour monitoring chart in place

**Finding:**

Activity plans do not include de-escalating/diverting strategies that reflect the resident past activities or are identified as assisting the individual resident.

**Corrective Action:**

Improvement is required to ensure activity plans identify individual strategies for de-escalating / diverting strategies.

**Timeframe (days):** 180 (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:**

Up until August 2013 the seven files reviewed documented RN evaluations completed four to six weekly, however the dementia clinical co-ordinator stated there had been a policy change to requiring RN evaluation three monthly for hospital level care residents and six monthly for rest home level care residents. Two of four resident files receiving hospital level care were overdue for their November evaluation (refer to CAR 1.3.3.3).

Changes to care plan when there is a change of health status between routine evaluations was sighted on files reviewed.

There are at least a one to three monthly reviews by the medical practitioners.

There are short term care plans (STCP) to focus on acute and short-term issues. Examples of STCP's used included; infections, wounds, and challenging behaviours (refer to 1.3.6.1).

D16.4a Care plans are evaluated three to six monthly or more frequently when clinically indicated (refer to CAR 1.3.3.3).

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> In previous certification audit areas requiring improvement were identified around; a) ensuring allergies/sensitivities or no known allergies are documented

on medication instruction charts and remains at this surveillance audit. b) self-administered medication is documented and assessment correctly completed. There is currently no residents self-administering medication so this finding is met; c) ensure G.P. signs medication instruction sheet identifying the completion of three monthly reviews, 14 of 14 medication charts reviewed included this information, so the finding is met; d) resident photos are updated as needed to ensure they reflect resident's current appearance. All photos were dated as taken in the last 12 months, this finding is met; e) G.P. signs medication instruction charts, this finding is on-going; f) there is no transcribing, 14 of 14 charts reviewed did not evidence transcribing. This finding is met.

Staff responsible for medication administration, which includes registered and enrolled nurses and care workers are trained and complete an annual competency or when they contribute to a medication error. There were significant numbers and types of medication errors during 2013 and both nurse managers ( hospital / rest home and dementia units) describe a focus on reducing these. Of three staff that contributed to a number of errors, two have left the service and one has been retrained and re-competency tested with a reduction in medication errors. During interviews with six registered nurses and four enrolled nurses they described the focus on medication errors and strategies implemented to reduce these and the re-competency process following an error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, subcutaneous fluids, blood sugars and oxygen/nebuliser use. Medication management training was held five times over a six month period in 2013, as a part of the focus on reducing errors ( January, April, May, July and October 2013).

Medications are stored in locked trolleys in the two treatment rooms located in the rest home and hospital unit and in the Iona dementia units. Controlled drugs are stored in a locked safe in the hospital / rest home treatment room and only the registered nurses have access and two staff (one being an RN), must sign controlled drugs out. Two of three residents receiving controlled drugs the time stated in the controlled drug register differed from that stated in the administration signing sheet, and this requires an improvement.

The service uses two weekly robotic packs. Robotic medications are checked on arrival by a registered nurse and any pharmacy errors are recorded and fed back to the supplying pharmacy.

Medication charts have photo ID's with, dates as taken within the last 12 months.

There is a list of standing order medications, that have been approved by the GP's, which only a registered nurse, in conjunction with the on-call nurse manager, can administer.

Staff signs for the administration of medications on medication sheet and these were correctly completed including time of medication administered and correspond with the instructions on the medication chart. The medication folders include a list of specimen signatures and competencies.

There are currently no residents self-administering at Peacehaven.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.Ps. The house G.P. used } to group sign medications on seven of 14 charts reviewed. Two of 14 charts reviewed did not state allergies or none known. Not all PRN medication charted included an indication for use. The residents group of medicine documents in the folders include colour coded alert pages with instructions and or warnings.

D16.5.e.i.2; 14 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. Medication audits are completed January, June and October 2013.

Five staff were observed administering medications across the four units from the robotic system in a safe manner and each referenced the medicine to

the medication instruction sheet.

Improvement is required to ensure: a) the times stated in the controlled drug register reflect the time the controlled drug was administered; b) complete six monthly controlled drug stocktakes; c) ensure all medication instructions are individually signed by the prescribing G,P.; d) PRN instructions include indication of use.

**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:** PA Moderate

**Evidence:**

Fourteen residents' medication charts were reviewed, which included the seven residents whose individual files were reviewed. Controlled drugs are stored in a locked safe in the hospital / rest home treatment room and only the registered nurses have access and two staff (one being an RN), must sign controlled drugs out. Two of three residents receiving controlled drugs the time stated in the controlled drug register differed from that stated in the administration signing sheet. There is a weekly check of controlled drug balances completed by a registered nurse, but no quantitative balance completed at least six monthly. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. The house G.P. used } to group sign medications on seven of 14 charts reviewed. Two of 14 charts reviewed did not state allergies or none known. Six of 14 charts the PRN medications did not include indications of use for all PRN medications charted.

**Finding:**

(i)Two of three residents receiving controlled drugs the time stated in the controlled drug register differed from that stated in the administration signing sheet. (ii)There is no quantitative balance completed at least six monthly. (iii) The house G.P. used } to group sign medications on seven of 14 charts reviewed. (iv) Two of 14 charts reviewed did not state allergies or none known. (v) Six of 14 charts the PRN medications did not include indications of use for all PRN medications charted

**Corrective Action:**

Improvement is required to: (i) the times stated in the controlled drug register reflect the time the controlled drug was administered; (ii) complete six monthly controlled drug stocktakes; (iii) ensure all medication instructions are individually signed by the prescribing G,P.; (iv) PRN instructions include indication of use; and (v) all medication charts state allergies or none known.

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

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

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

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

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

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

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

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

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

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

**Corrective Action:**

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

### **Standard 1.3.13: 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:** PA Moderate

**Evidence:**

All staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen, that contains one walk-in fridge, one standalone fridge, three freezers and a pantry. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a seasonal rolling menu. Residents have a nutritional profile developed on admission with a copy placed in a kitchen resident folder, which include preferences and nutritional requirements including any special utensils etc., this is reviewed six monthly, as part of the care plan review or sooner, if required. Changes to residents' dietary needs are communicated to the kitchen by the registered nurses. Monthly resident meetings are held and meals are discussed. Regular audits of the kitchen including cleanliness, fridge/freezer temperatures and food temperatures are undertaken and documented last completed in May 2013. Records sighted confirm temperatures meet recommended guidelines.

E3.3f, ARHSS D15.2f: there is evidence that there are additional nutritious snacks available over 24 hours. Sandwiches are available at all times. Special diets being catered for include soft diets, puree diets and diabetics.

Residents and family interviewed report satisfaction with food choices, meals are well presented (observed) and alternative meals are offered, as required.

Improvement is required to ensure residents with nutritional recommendations are: a) communicated to the kitchen; b) documented as implemented or reason why not stated; c) evaluated according to risk factors; d) resident fluid intake is accurately documented; and e) a plan for addressing any short-fall in intake documented and implemented.

#### **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:**

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<p><b>Evidence:</b></p> <p>A report from a dietitian who saw a resident while in hospital (DHB) contained advice as to dietary adjustments in response to weight loss. On sighting the resident dietary profile in the kitchen the resident was to receive complan and on interview the cook spoke to the provision of this, however was unaware of the dietary report from hospital admission and the added suggestions contained within it. On interview with the nurse manager they acknowledged the report had not been actioned.</p> <p>There is a folder in each area of the facility containing all forms to be completed to evidence monitoring of residents, which included fluid balance charts. In the two dementia units five residents' fluid balance charts for the seven previous days were reviewed. There is recorded evidence the highest total fluid intake for any resident was 1100 mils in a 24 hour period.</p> <p>There were no recorded alerts and staff interviewed did not report receiving instruction to address these low fluid intakes.</p>
<p><b>Finding:</b></p> <p>(i)A resident's dietitian recommendations were not documented as actioned. (ii) Five residents fluid balance charts for the seven previous days were reviewed; the highest total fluid intake for any resident was 1100 mils in a 24 hour period.</p>
<p><b>Corrective Action:</b></p> <p>(i)Ensure residents with nutritional recommendations are communicated to the kitchen; (ii) a plan for addressing any short-fall in fluid intake be documented and implemented.</p>
<b>Timeframe (days):</b> 30 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The facility building warrant of fitness was sighted as current, date of issue 22/01/13.

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

All buildings, plant, and equipment comply with legislation.

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

A previous audit identified improvement required to fit a new water valve to regulate water temperatures in bedrooms and monitoring of temperatures. Evidence was sighted that temperatures were being monitored. This finding is met. On two occasions sighted when the temperature was above 45 degrees action to correct this was documented and repeat monitoring stated temperature returned to below 45 degrees.

#### 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.)*

## 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:**

Documented systems are in place to ensure the use of restraint is actively minimized. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.

Interview with the restraint co-ordinator was conducted and evidences there is no restraint or enabler use in the dementia units. The hospital / rest part of the facility restraint register evidences there are 14 restraints and seven enablers used.

There are bi monthly meetings of the restraint committee, terms of reference and meeting minutes were sighted for 2013.

Restraint practises are also discussed at the monthly quality improvement meetings, sighted minutes of meetings for 2013.

Staff interviews and staff records evidence guidance has been given on restraint practice, enabler usage and prevention and/or de-escalation techniques. The definition of restraint and enabler is congruent with the definition in NZS 8134.0. The process of assessment and evaluation of enabler use is recorded.

Staff education on RMSP /Enabler and challenging behaviour is conducted monthly, sighted attendance records.

Restraint audit was conducted in February and August 2013.

The required improvement from previous audit around enablers has been met.

The ARC requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

### Standard 2.2.3: 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 practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Interview with the restraint co-ordinator was conducted and evidences there is no restraint or enabler use in the dementia units. The hospital / rest part of the facility restraint register evidences there are 14 restraints and seven enablers. Review of two clinical files of residents' utilising restraint evidence assessments, consent, monitoring and review of restraint use is conducted. The restraint committee reviews restraint use bi monthly and restraint is also discussed at monthly quality improvement meetings, sighted minutes of meetings.

The required improvements around restraint monitoring is met.

The ARC requirement is met.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Infection Control (IC) co-ordinator's position is assigned to the dementia unit clinical co-ordinator and supported by the rest home /hospital nurse manager.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. The surveillance policy states the routine/planned surveillance programme is organised and promoted via QPS system. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. An individual infection report form is completed for each infection.

Infection control data is discussed at monthly quality improvement meetings and staff meetings.

Staff interviews confirm infection control is discussed at meetings and any resident infections are communicated to staff at staff handovers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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