# The Ultimate Care Group Limited - Churtonleigh Lifecare

## Current Status: 20 February 2014

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

## General overview

Churtonleigh Lifecare provides residential care for up to 35 residents who require hospital level care and rest home level care. Occupancy on the day of the audit is at 32. The facility is operated by Ultimate Care Group Limited. There is a low turnover of staff. Residents and family members interviewed were very positive about the care provided.

Three particular strengths relating to quality improvement projects undertaken have been identified during this audit. These relate to the provision of education, and a quality initiative involving a geriatrician from the local district health board There are no areas identified as requiring improvement during this audit.

## Audit Summary as at 20 February 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 20 February 2014

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

### Organisational Management as at 20 February 2014

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 20 February 2014

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| 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 20 February 2014

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| 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 20 February 2014

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| 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 20 February 2014

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

## Audit Results as at 20 February 2014

### Consumer Rights

Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Residents and their families are informed of their rights at admission and throughout their stay.

Relevant information is provided prior to, during and following admission and an opportunity set aside at admission, for discussion, to ensure residents and family/whanau understand their rights under the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and understand the admission agreement. The admission agreement details inclusions and exclusions of service and is able to be taken away prior to signing for legal advice to be sought if required.

Available at the facility entry, are copies of information relating to the Nationwide Health and Disability Advocacy Service in addition to many other services. A local pastor is available to act as an advocate for the residents if it is required.

The facility does not currently support anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs and staff demonstrated an awareness of the need to provide a service that is responsive to these needs. Residents receive services that have regard for their dignity, privacy and independence.

Open disclosure principles are demonstrated. Communication methods include formal and informal family/whanau meetings/contact, an 'open door policy' by management and regular residents' meetings. Incident reports, progress notes and family communication records verify family notification, when appropriate.

Informed consent policy and processes are explained to residents and families/whanau and implemented by the service. Staff demonstrate awareness of ensuring residents are informed and have choices related to the care they receive.

Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. Residents have access to visitors of their choice and are supported to access community services.

Residents and family/whanau members are able to raise concerns and access support services as required and residents rights to make a complaint is respected and upheld. The facility manager is responsible for complaints and a complaints register is maintained.

### Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Churtonleigh Lifecare. A business plan and various quality documents were reviewed and include a vision statement, core values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Churtonleigh Lifecare including regular monthly reporting by the facility manager to The Ultimate Care Group head office. The facility manager and clinical services manager are both registered nurses with extensive experience in the aged care sector.

Churtonleigh Lifecare has a well-established and documented quality and risk management system that is maintained to a high standard. There is comprehensive evidence available indicating that quality improvement data is being collected, collated, and analysed to identify trends and improve service delivery. A particular strength of the service provider is that they identify any areas that need improvement and undertakes quality improvement projects: there is robust quality improvement project evidence available including evidence of improvements to service delivery as a result of these quality improvement projects.

There is an internal audit programme in place, risks are identified, and there is a hazard register. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from The Ultimate Care Group head office.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), pharmacists, dietitians, and general practitioners (GPs) is occurring. There is evidence available indicating an in-service education programme is provided for staff and various methods of delivery are used to ensure staff receive ongoing education. The service provider recently implemented a quality initiative as they recognised that individual staff have different learning styles and needs. As a result of this quality initiative staff attendance at education has doubled in a 12 month period and staff report they appreciate being able to access learning via different delivery methods. Improvements to service are noted as a result of this quality improvement project and one criterion is rated continuous improvement. Review of staff records provides evidence that human resource processes are followed (e.g. reference checking, criminal vetting, and interview questionnaires are completed, and individual education records are maintained).

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager is on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

All records sighted are secure. Residents' current files are stored in a locked cupboard. Archived files are in a cupboard secured by a lock and documents dated for easy retrieval.

### Continuum of Service Delivery

Information packs contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. Churtonleigh Lifecare works closely with the Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. An area of continuous improvement is identified round Churtonleigh Lifecare's implementation of a coordinated approach between Capital Coast District Health Board (CCDHB) geriatric services and Churtonleigh Lifecare. This approach has resulted in a reduction in admissions to CCDHB. Residents’ files provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate, their family.

The planned activities programme is developed based on residents’ strength and interests and includes a diversity of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice which is seen to be consistent with these documents.

Menus are reviewed by a dietitian. Any special dietary requirements and need for assistance with meals or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are complimentary of the food service provided.

### Safe and Appropriate Environment

All but one bedroom, provide single accommodation and have wash hand basins. There is an adequate number of communal toilet and shower facilities available throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are separate lounges and a dining area throughout the facility. External areas are available for sitting and shading is provided in these external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of hazardous substances and emergency management. Visual inspection provides evidence of safe storage of chemicals and equipment. Protective equipment and clothing is provided and is used by staff. Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services.

### Restraint Minimisation and Safe Practice

The service has nine residents assessed as requiring the use restraints. There is one resident using an enabler at the time of audit. Policies and procedures implemented meet the requirements of the standards. The service maintains a process to determine approval for all types of restraint, including enablers. There is a rigorous assessment process undertaken and at least three monthly reviews and evaluations of each resident who has a restraint or an enabler in use.

Assessment processes fully inform planning of care and identify known risks. Resident safety is paramount to restraint use and is fully understood by clinical staff. Staff receive on-going education on restraint minimisation and safe practice, which includes prevention, de-escalation techniques and managing challenging behaviours.

Restraint use and analysis are reported at all levels of the organisation and shows a gradual decrease in the use of restraint over the past year.

### Infection Prevention and Control

The Ultimate Care Group Limited corporate infection control management systems are fully implemented at Churtonleigh Lifecare to minimise the risk of infection to residents, service providers and visitors. Documented policies and procedures reflect current accepted good practice and legislative requirements and are readily available for staff access.

The facility manager is the infection control co-ordinator and there is evidence they attend appropriate ongoing infection prevention and control education.

On-going infection control education has been provided for staff. Review of documentation at Churtonleigh Lifecare provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organization. Results of surveillance are reported on The Ultimate Care Group Limited electronic database and are collated and reported to the monthly quality and staff meetings and to the two monthly infection control/health and safety meetings. Infection surveillance data is also reported to the governing body through monthly reports. Copies of graphs of clinical indicators are displayed in the staff room and staff interviewed report this information is available for them.

# 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**

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| **Legal entity name:** | Churtonleigh Lifecare |
| **Certificate name:** | The Ultimate Care Group Limited |

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| **Designated Auditing Agency:** | DAA Group Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Churtonleigh Lifecare | | | |
| **Services audited:** | Medical and Geriatric Hospital. Rest Home | | | |
| **Dates of audit:** | **Start date:** | 20 February 2014 | **End date:** | 21 February 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** |  |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8.5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 4 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 20.5 | Total audit hours | 52.5 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 14 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed |  | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) |  | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXX, Managing Director of Wellington 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:

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| --- | --- | --- |
| 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 | Not Applicable |
| 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 Friday, 14 March 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Churtonleigh Lifecare provides residential care for up to 35 residents who require hospital level care and rest home level care. Occupancy on the day of the audit is at 32. The facility is operated by Ultimate Care Group Limited. There is a low turnover of staff. Residents and family members interviewed were very positive about the care provided.  Three particular strengths relating to quality improvement projects undertaken, the provision of education, and a quality initiative involving a geriatrician from the local district health board have been identified during this audit. There are no areas identified as requiring improvement during this audit. |

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| **Outcome 1.1: Consumer Rights** |
| Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Residents and their families are informed of their rights at admission and throughout their stay.  Relevant information is provided prior to, during and following admission and an opportunity set aside at admission, for discussion, to ensure residents and family/whanau understand their rights under the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and understand the admission agreement. The admission agreement details inclusions and exclusions of service and is able to be taken away prior to signing for legal advice to be sought if required.  Available at the facility entry, are copies of information relating to the Nationwide Health and Disability Advocacy Service in addition to many other services. A local pastor is available to act as an advocate for the residents if it is required.  The facility does not currently support anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs and staff demonstrated an awareness of the need to provide a service that is responsive to these needs. Residents receive services that have regard for their dignity, privacy and independence.  Open disclosure principles are demonstrated. Communication methods include formal and informal family/whanau meetings/contact, an 'open door policy' by management and regular residents' meetings. Incident reports, progress notes and family communication records verify family notification, when appropriate.  Informed consent policy and processes are explained to residents and families/whanau and implemented by the service. Staff demonstrate awareness of ensuring residents are informed and have choices related to the care they receive.  Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. Residents have access to visitors of their choice and are supported to access community services.  Residents and family/whanau members are able to raise concerns and access support services as required and residents’ rights to make a complaint is respected and upheld. The facility manager is responsible for complaints and a complaints register is maintained. |

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| **Outcome 1.2: Organisational Management** |
| The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Churtonleigh Lifecare. A business plan and various quality documents were reviewed and include a vision statement, core values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Churtonleigh Lifecare including regular monthly reporting by the facility manager to The Ultimate Care Group head office. The facility manager and clinical services manager are both registered nurses with extensive experience in the aged care sector.  Churtonleigh Lifecare has a well-established and documented quality and risk management system that is maintained to a high standard. There is comprehensive evidence available indicating that quality improvement data is being collected, collated, and analysed to identify trends and improve service delivery. A particular strength of the service provider is that they identify any areas that need improvement and undertakes quality improvement projects: there is robust quality improvement project evidence available including evidence of improvements to service delivery as a result of these quality improvement projects.   There is an internal audit programme in place, risks are identified, and there is a hazard register. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from The Ultimate Care Group head office.   There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), pharmacists, dietitians, and general practitioners (GPs) is occurring. There is evidence available indicating an in-service education programme is provided for staff and various methods of delivery are used to ensure staff receive ongoing education. The service provider recently implemented a quality initiative as they recognised that individual staff have different learning styles and needs. As a result of this quality initiative staff attendance at education has doubled in a 12 month period and staff report they appreciate being able to access learning via different delivery methods. Improvements to service are noted as a result of this quality improvement project and one criterion is rated continuous improvement. Review of staff records provides evidence that human resource processes are followed (e.g. reference checking, criminal vetting, and interview questionnaires are completed, and individual education records are maintained).   There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager is on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.    All records sighted are secure. Residents' current files are stored in a locked cupboard. Archived files are in a cupboard secured by a lock and documents dated for easy retrieval. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Information packs contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. Churtonleigh Lifecare works closely with the Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.  There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. An area of continuous improvement is identified round Churtonleigh Lifecare's implementation of a coordinated approach between Capital Coast District Health Board (CCDHB) geriatric services and Churtonleigh Lifecare. This approach has resulted in a reduction in admissions to CCDHB and stress to residents. Residents’ files provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate, their family.  The planned activities programme is developed based on residents’ strength and interests and includes a diversity of activities and involvement with the wider community.   Well defined medicine policies and procedures guide practice which is seen to be consistent with these documents.  Menus are reviewed by a dietitian. Any special dietary requirements and need for assistance with meals or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are complimentary of the food service provided. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| All but one bedroom provide single accommodation and have wash hand basins. There is an adequate number of communal toilet and shower facilities available throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as a carer. There are separate lounges and a dining area throughout the facility. External areas are available for sitting and shading is provided in these external areas. An appropriate call bell system is available and security systems are in place.  There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of hazardous substances and emergency management. Visual inspection provides evidence of safe storage of chemicals and equipment. Protective equipment and clothing is provided and is used by staff. Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has nine residents assessed as requiring the use restraints. There is one resident using an enabler at the time of audit. Policies and procedures implemented meet the requirements of the standards. The service maintains a process to determine approval for all types of restraint, including enablers. There is a rigorous assessment process undertaken and at least three monthly reviews and evaluations of each resident who has a restraint or an enabler in use.  Assessment processes fully inform planning of care and identify known risks. Resident safety is paramount to restraint use and is fully understood by clinical staff. Staff receive on-going education on restraint minimisation and safe practice, which includes prevention, de-escalation techniques and managing challenging behaviours.  Restraint use and analysis are reported at all levels of the organisation and shows a gradual decrease in the use of restraint over the past year. |

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| **Outcome 3: Infection Prevention and Control** |
| The Ultimate Care Group Limited corporate infection control management systems are fully implemented at Churtonleigh Lifecare to minimise the risk of infection to residents, service providers and visitors. Documented policies and procedures reflect current accepted good practice and legislative requirements and are readily available for staff access.  The facility manager is the infection control co-ordinator and there is evidence they attend appropriate ongoing infection prevention and control education. On-going infection control education has been provided for staff. Review of documentation at Churtonleigh Lifecare provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organization. Results of surveillance are reported on The Ultimate Care Group Limited electronic database and are collated and reported to the monthly quality and staff meetings and to the two monthly infection control/health and safety meetings. Infection surveillance data is also reported to the governing body through monthly reports. Copies of graphs of clinical indicators are displayed in the staff room and staff interviewed report this information is available for them. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 98 | 0 | 0 | 0 | 0 | 0 |

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

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.2.3.7 | A process to measure achievement against the quality and risk management plan is implemented. | CI | There is an established, documented, and maintained quality and risk management system in place at Churtonleigh Lifecare that is maintained to a high standard, and reflects continuous quality improvement principles. There is comprehensive evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is evidence available indicating the service provider identifies any areas that needs improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. For example, a quality improvement initiative relating to reducing harm from falls has been implemented. As a result of this quality initiative one resident who was identified as a high falls risk and had four falls in a two month period has had a 75% reduction in falls within a two week period. Another quality initiative was recently implemented to improve medicine management following analysis of data (see link 1.3.12) Documentation reviewed during this audit indicates continuing improvement to service provision. |
| HDS(C)S.2008 | Criterion 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. | CI | There is comprehensive evidence that ongoing education is provided and is attended by staff. The facility manager recognised that staff have different learning styles and developed a quality initiative that was aimed at improving compliance with education. This quality initiative also recognises that shift workers, especially those working night shifts, and workers with young children do not always find it easy to attend education sessions during the day. Review of documentation associated with this quality initiative demonstrates the average time spent on training has increased and the attendance rates have increased. The facility manager during interview states the education is of a higher quality as it is tailored to the needs and learning styles of each staff member. |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | CI | Implementation of a coordinated approach between CCDHB geriatric services and Churtonleigh Lifecare has resulted in less stress to residents and a reduction in admissions to CCDHB by 50% when compared to the previous 12 months. Sighted supporting documentation and interviews with the GP, clinical services manager and facility manager are all satisfied with the process and confident it produces the desired outcome. |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment in which residents receive services in accordance with human rights legislation. Residents receive an information pack on admission that includes a copy of the admission agreement, the Code of Health and Disability Services Consumers’ Rights (the Code) and the advocacy services brochure, and advice is able to be sought prior to admission. Brochures are also displayed and available to the public at the front entrance.   The staff of Churtonleigh Lifecare demonstrates knowledge of the Code, receiving education on the Code at orientation and in-service training sessions, last held in October 2013. Evidence of this is sighted in seven of seven staff training records and verified in interview with six of six clinical staff.   Compliance with the Code is monitored through resident and relative satisfaction surveys. Interviews with three of three family/whanau members and seven of seven residents confirm satisfaction with the service fulfilling its obligations under the consumer rights legislation and report that they are treated with respect.  Situations observed during the audit in relation to the provision of care provide evidence that residents are given choices, residents' decisions are respected, residents are treated with respect, residents' privacy being is protected (eg, notes being locked away, confidentiality of information, cordless phone to make phone calls, staff knocking on residents' doors prior to entering their rooms), and residents are addressed by a preferred name.  Clinical staff are observed to explain procedures being undertaken and seek verbal acknowledgement for the procedure to proceed prior to it being commenced.   The ARRC requirements are met |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment in which residents are informed of their rights. Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code), receiving a copy of the Code in the admission pack. The pack also includes information on the Nationwide Health and Disability Advocacy service, access to support services, the Ministry of Health’s (MOH) information on long term residential care for older people, information on applying for a residential care subsidy, and the facilities outlining its range of services and costs. Advice to accessing interpreters is available should assistance be required to provide the information in a language and format that is suitable to the consumer.   The admission meetings covers all the content of admission pack information and the details in the admission agreement. Admissions are undertaken by the Registered Nurse (RN). Management has an open door policy. The Clinical Services Manager is available for explanation, discussion and clarification about the Code with the consumer as verified by three of three family/whanau and seven of seven residents interviewed.   Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Information about the National Health and Disability Advocacy Service is displayed in the reception area and is easily accessible. A local pastor is available as a residents advocate if required.   The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence. All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. Bedrooms are of a size that allow appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their rooms, enabling residents to have privacy when making phone calls. There are locks on all toilet and bathroom doors and staff are observed to knock prior to entering. The staff room provides privacy of stored information. Privacy when discussion concerning residents takes place is in residents' rooms. Staff education on privacy takes place at orientation, and during in-service education (last presented in October 2013), as verified by six of six clinical staff interviews and sighted staff education records in seven of seven staff files.   Care plans identify residents like and dislikes and interventions identify the assistance the resident requires to meet residents' needs.   Residents are addressed in a respectful manner and by their preferred names (confirmed by observation and during interviews with two of two rest home residents, five of five hospital residents and three of three family members). Residents are assisted to maintain dignity and respect and to ensure the residents' sexuality and intimacy needs are both supported and protected, while protecting the wellbeing of others. Residents are encouraged by staff to be as active as is safely possible.  The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Staff demonstrate an awareness of the need to provide a service that is responsive to these needs. Residents and families verify they receive clinical services that have regard for their dignity, privacy and independence.  Consumers are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The Individual employment agreement, Code of Conduct, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. As confirmed by six of six clinical staff interviews, all staff said they would report anything of concern to management. Interviews with three of three family/whanau members and seven of seven residents ( two rest home and five hospital), confirm they have no concerns related to abuse or neglect. All comments are positive.   Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident and family participation. Evidence of this is sighted in seven of seven files reviewed, seven of seven residents, three of three family/whanau and six of six staff interviews and confirm services implemented enable the residents privacy, independence dignity and respect.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare does not currently support anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required. There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The Clinical Services Manager is able to identify who to contact if a Maori support person or advisor is required.  The organisation has a model of care which ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing. Residents who identify as Maori will be supported in their right to practise their cultural values and beliefs.  Staff receives annual education in relation to Cultural Safety and The Treaty of Waitangi. Evidence is sighted and verified of education in May 2013 with regards to end of life care of Maori residents.   The requirements of the ARRC are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment that enables consumers to receive culturally safe services that recognise and respect individual ethnic, cultural and spiritual values and beliefs.  Included in the admission and ongoing assessment process is the resident's specific cultural and spiritual needs, values and beliefs are identified and documented to inform the care planning process. Cultural and individual values and beliefs are identified in care planning and activity planning to ensure that specific needs and objectives are met. These include, but are not limited to: • Language and communication needs • Dietary practices • Religious practices • Dress and personal presentation expectations • Personal hygiene practices    Residents and family/whanau are consulted about individual values and beliefs to ascertain if there are any special requirements needed to be met by the service. Seven of seven residents and three of three family/whanau interviews confirm staff implement cares to meet their needs.  Sighted in the general information session of the admission information, clergy of all denominations visit regularly, however other requests can be arranged with management. A multi-denominational church service is sighted in the activities programme. Some residents’ families access their own spiritual support from the community, as evidenced by one of one residents file and verified by interview.  Open visiting policy allows family/whanau to visit when they are able.  The ARRC requirements are met. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.  Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicates effectively with them and residents are kept up to date.  Orientation/induction processes inform staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct, and informs staff about working within their professional boundaries. If a resident would like to make a gift to a staff member, the staff member must inform the resident this is not permitted. A signature acknowledging the terms related to all this information is located in all employment agreements. The manager will action formal disciplinary procedure if there is an employee breach of conduct.  The ARRC requirements are met. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment that encourages good practice. All policies sighted are up to date and relevant reference is made to related sources, legislation and the Health and Disability Services Standards requirements. They are reflective of evidence based rationales, which are monitored and evaluated.  New employees complete a comprehensive orientation/induction programme that is relevant to the role they undertaken. The service supports and encourages staff with appropriate on-going education relevant to the role they undertaken. The service has an in-service and on line education programme in place which is monitored at organisational level to ensure all key components of service delivery is covered to meet contractual requirements and residents' need. All care staff have or are undertaking the Aged Care Education and Dementia training (sighted). All RN’s who administer medication have yearly assessments to determine competency (sighted). Care givers who are required to check medication for the RN are assessed as being competent to do so. All registered nurses (RN’s) have an up to date first aid certificate (sighted). RN education is supported by District Health Board, the specialist services that they operate and the local Hospice services. All RN’s have completed the ACE dementia training (sighted). Palliative Care Training (9 modules) is being offered on site to RN’s and senior care givers by the hospice educator(sighted) RNs are assessed as competent to manage syringe drivers and have attended wound care management courses.   The two diversional therapists have recognised diversional therapy training (sighted). Kitchen staff have training in food safety (sighted and verified by interviews with staff and documented in staff training records). Laundry and cleaning staff have satisfied Ecolab’s training programme.  Six of six care staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner. Seven of seven staff files verify education programme content.  Seven of seven residents and three of three family/whanau verify satisfaction with the services provided. An interview with the GP, verifies he is happy with the services provided. The service responds promptly and correctly to his requests and is prompt in requesting his input if needed. GP comments include “I would put my parents in this facility”.   Resident satisfaction surveys undertaken annually indicate overall the satisfaction is high.  The ARRC requirements are met |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment conducive to effective communication to enable consumers to communicate effectively. The Open Disclosure policy is implemented by the service to ensure residents receive full and frank information in an open and honest manner. Communication is undertaken in manner that reflects the principles of open disclosure. Management operate an open door policy. Resident meetings, a relaxed, open, homely environment, formalised family/whanau meetings and open and honest reporting of incidents and accidents, provide an environment conducive to effective communication.  Communication with relatives is documented in a communication sheet which is kept in the residents' files (completed forms are sighted in seven of seven residents' files audited). Churtonleigh Lifecare has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Three of three caregivers interviewed confirm they understand that relatives and residents must be informed of any changes in care provision. Seven of seven residents (two from the rest home and five from the hospital) and three of three family/whanau members interviewed, confirm that they are always consulted and informed of any untoward event or change in care provision, and are included in care reviews.  Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed). Evidence of open disclosure is documented on the incident and accident form. It is also documented in the resident's file. Residents and family confirm communication with staff is open and effective (verified in seven of seven resident and three of three family/whanau interviews, and sighted during audit).   Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau. Staff make adequate time to talk with residents and families (confirmed in interviews with three of three care staff, three of three RN’s, seven of seven residents and three of three family members). There is sufficient space in each single room to permit private discussions. At admission the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about and at what time of day they wish to be notified. As indicated some residents request family not to be informed.    There are no residents at present that require interpreting services however, during interview with the manager and the Clinical Services Manager, both confirm their awareness of how to contact the interpreter service if required. Interviews with three of three family members and seven of seven residents confirm they are happy with the information and involvement they receive.  The ARRC 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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides residents and where appropriate their family/whanau with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided. Residents are able to choose their GP of choice. The RN discusses information on informed consent with the resident and family/whanau on admission. Consents requests the resident's agreement to; collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organised by Churtonleigh. Informed consent is evident in observation of day to day activities on the two days of audit, with residents being actively involved in the decision making process. Seven of seven files reviewed evidenced informed consent forms signed on admission. 14 of 14 medicine charts had residents’ photographs for identification. Documentation identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. The consumer satisfaction survey results indicate family/whanau satisfaction with involvement in care.  An advanced directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advanced directive is filled out in consultation with the resident's doctor and resident’s wishes guide care planning, with consent on non consent to be revoked at any time. Advanced directives are sighted in seven of seven files.   Verbal consent is obtained prior to an intervention being carried out (confirmed in interview with seven of seven residents and three of three family members).   Staff education on consent takes place during their orientation and during in-service education (yearly). Staff have an understanding of the informed consent process (confirmed in interviews with six of six clinical staff). The manager, clinical services manager, three of three RN’s, three of three caregivers, cleaner, activities officer and seven of seven residents, confirm their understanding and knowledge of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. Staff respect residents' choices and allow residents to change their mind at any time. Examples are sighted related to respecting residents' wishes; food likes and dislikes being catered for; activities in the activities programme and individuals involvement is at the resident's request; and an environment where choices are openly acknowledged and offered. All seven of seven resident interviews confirm their choices are respected by staff and staff confirm they respect the resident's right to decline any services offered.  Care plans are signed by the resident and/or family/whanau, where appropriate, to say they have read and agree with what is written.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service recognises and facilitates the right of residents to advocacy / support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility and is included in the admission information. Churtonleigh Lifecare has a local pastor who is willing to act as the residents advocate if required and is on site monthly. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families/whanau are aware of their right to have support persons, as verified in seven of seven resident and three of three family/whanau interviews.  Staff demonstrate appropriate knowledge related to the resident's right to have an advocate or support person of choice at any time, as verified by three of three care givers, one of one nurse manager, one of one clinical nurse manager and three of three RN’s.  The ARRC requirements are met |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment whereby consumers are able to maintain links with family/whanau and their community and residents are encouraged to maintain these links. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources.   The service acknowledges values and encourages the involvement of families/whanau in the provision of care. The activities programme actively supports community involvement and accesses community resources. Seven of seven residents and three of three family members confirm that visitors can visit freely and there is access to community services. It was observed that there were visitors coming and going from the facility during the audit. File reviews, manager and the recreational officer confirm community services used by the facility include: - local social groups,  - the local community centre activities - other aged care facilities - local church groups and services - the CCDHB nurse specialists - Service Coordination - the local needs assessment and service coordination agency (NASC)  - the service has a podiatrist who visits regularly - residents have the GP of their choice - CCDHB outpatient and inpatient services as appropriate.  The ARRC requirements are met |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility and there are two complaints recorded for 2013 and none for 2014. One of these recorded complaints is a request for information by the Health and Disability Commissioner (HDC) from the provider following allegations made against a general practitioner (GP). A letter from the HDC office dated 11 October 2013 states the issue has been resolved.  A complaints register is also maintained at The Ultimate Care Group (UCG) Head Office for complaints that are escalated up to them (not reviewed during this audit). Reporting of complaints occurs via monthly meetings and via the facility manager’s (FM) reports to the UCG Head Office. The FM reports there have been no complaint investigations by the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.   Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held two monthly and review of these minutes provides evidence of residents ability to raise any issues they have, and this was confirmed during interviews of residents (two rest home and five hospital) and relatives (three).  A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality meeting minutes and manager's monthly reports evidences reporting of complaints.  The ARC requirements are 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.

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

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

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

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Churtonleigh Lifecare. UCG has established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems. The Regional Operations Manager for UCG is interviewed and confirms reporting processes and monitoring of quality and risk management goals.  A ' Business Plan 2014 - 2015' and 'Quality and Risk Management Plan for Churtonleigh Lifecare January 2014 - January 2015' are reviewed and include a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed are documented values, mission statement and philosophy, which are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.    There is an ' Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) and is responsible for reviewing clinical issues and policies and procedures following feedback from each of the 16 UCG sites. Each of the four CSMs is responsible for liaising with four or five UCG sites to ensure their participation in the process. 'Ultimate Care Group Clinical Governance Group Terms of Reference' reviewed. The CSM from Churtonleigh Lifecare is a member of this group.  Meeting schedules and minutes reviewed and monthly quality and staff meetings are held as are two monthly resident, registered nurse (RN) and health and safety/infection control meetings. Meeting minutes are available for review by staff along with clinical indicator reports, graphs, and benchmarking data.   The facility manager (FM) provides weekly and monthly reports to the governing body and these are reviewed. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators. The clinical services manager (CSM) reports on incidents and accidents.  The facility is managed by a very experienced management team consisting of a facility manager (FM) and a clinical services manager (CSM) and both are registered nurses with current practising certificates. The FM has worked in the aged care sector for the last 29 years, the last 12 years as manager at Churtonleigh Lifecare. The CSM, who is responsible for oversight of the clinical care of residents, has worked in the aged care sector for the last 22 years in various roles. Review of the managers' personal files and interview of the FM and CSM indicates the managers undertake training in relevant areas. Twenty four hour RN cover is provided and the CSM is responsible for oversight of clinical care provided to residents. Support for the FM and CSM is provided by a Regional Operations Managers for UCG.  Churtonleigh Lifecare is certified to provide hospital level care and rest home level care and there are 35 beds provided. On day one of this audit there are 27 hospital residents and five rest home residents. The Ultimate Care Group Limited have contracts with the DHB to provide aged related residential care (rest home and hospital services) and aged respite care.   The ARC 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are appropriate systems in place to ensure the day-to-day operations of the service continues should the facility manager (FM) and/or the clinical services manager (CSM) be absent. The CSM relieves the FM if they are absent and the FM relieves the CSM if the CSM is absent. Twenty four hour RN cover is provided.   An UCG Regional Operations Manager, and other personnel from UCG Head Office are also available for assistance and support as required and this is confirmed during interview of the Regional Operations Manager. Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the FM and CSM confirms their responsibility and authority for their roles.   The requirements of the ARC are met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Ultimate Care Group (UCG) quality and risk management systems are fully imbedded at Churtonleigh Lifecare. Churtonleigh Lifecare has a well-established, documented quality and risk management system that is maintained to a high standard and reflects continuous quality improvement principles. There is comprehensive evidence available indicating that quality improvement data is being collected, collated, and analysed to identify trends and improve service delivery. As part of this process the service provider identifies any areas that needs improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. There is robust quality improvement project evidence available including evidence of improvements to service delivery as a result of these quality improvement projects. As a result of the improvements to service noted as a consequence of these quality improvement projects, one criterion (1.2.3.7) relating to quality and risk management systems is rated continuous improvement.  UCG launched 'Releasing Time to Care' (RTTC) modules at some trial sites in January 2012 and rolled it out to all UCG sites in August 2012. Churtonleigh Lifecare was one of the trial sites and during interview the Project Manager for UCG describes Churtonleigh as ‘the leader in the group’.  There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed. Review of quality improvement data provides evidence the data is being reported to UCG head office via their intranet as well as to staff via various meetings. Quality improvement and staff meetings are held monthly, clinical/registered nurses meetings are held two monthly, as are combined health and safety/infection control meetings. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Resident meetings are held two monthly and the meeting minutes are reviewed.  Family/whanau and residents satisfaction survey was completed in December 2013 via UCG head office. Collated results are reviewed and indicate the majority of responders are either satisfied or very satisfied with the various aspects of service provided.  The 'Quality and Risk Management Plan For Churtonleigh Lifecare January 2014 – 2015' is used to guide the quality programme and includes quality goals and objectives.   UCG implemented an electronic database (Inscribe/GOSH database) in November 2012 which is used to input clinical indicators on a daily basis. This information is available for review by staff at UCG head office. Information on this database, including benchmarking graphs, is reviewed during this audit. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly quality meetings. A quality improvement initiative relating to improvement of processes surrounding medicine management was recently implemented as part of the RTTC process following analysis of medication data and is not yet completed.  Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. There is documented evidence available indicating that issues identified as requiring follow through at meetings are discussed at subsequent meetings (eg, quality, staff, residents, health and safety/infection control and RN meetings).  Staff interviewed report they are kept well informed of quality and risk management issues, including clinical indicators. Copies of meeting minutes are available for staff to review in the staff office. Graphs of clinical indicators are displayed in a staff area.   The facility manager is responsible for providing a 'Weekly and Monthly Report' to UCG Head Office and these provide evidence of reporting of clinical indicators and quality improvements - including education and internal audits. Other areas reported on include occupancy, staffing and HR, Resident ‘Ins and Outs’, Property/Environmental Issues, Financial, General Comments, Compliance/Indicator Summary.    Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The CAG from UCG is responsible for reviewing policies and procedures and the CSM from Churtonleigh Lifecare is a member of this advisory group. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.   There is a Health and Safety Manual available that includes relevant policies and procedures. There is a Hazard Reporting system available and a Hazard Register. Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and reviewed and all biomedical equipment has appropriate performance verified stickers in place.  The requirements of the ARC 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.

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

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

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

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

##### **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.

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| 'Quality Improvement Plan, Ultimate Care Group' reviewed and outlines audits to be completed for each month. Audits completed for 2013 and 2014 are reviewed.  Processes are in place for the collection of key performance and risk data, such as: Accident/incident data - reported by area, by type, and time of event; Infections; Complaints data. This data is reviewed.  Documentation reviewed, such as reports, registers and forms provides evidence of appropriate data collection for accident / incidents and complaints.   There are monthly quality and staff meetings as well as two monthly RN and health and safety/infection control meetings. Meeting minutes reviewed demonstrate that quality and risk issues, including numbers of events, are being discussed at these meetings (e.g. accident/incident/event reporting outcomes, complaints, audit outcomes, infection control, health & safety, restraint usage). This finding is confirmed during interviews of staff. |
| **Finding:** |
| There is an established, documented, and maintained quality and risk management system in place at Churtonleigh Lifecare that is maintained to a high standard, and reflects continuous quality improvement principles. There is comprehensive evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is evidence available indicating the service provider identifies any areas that needs improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. For example, a quality improvement initiative relating to reducing harm from falls has been implemented. As a result of this quality initiative one resident who was identified as a high falls risk and had four falls in a two month period has had a 75% reduction in falls within a two week period. Another quality initiative was recently implemented to improve medicine management following analysis of data (see link 1.3.12) Documentation reviewed during this audit indicates continuing improvement to service provision. |
| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG Inscribe/GOSH electronic database, and filed in resident files. 2013 and 2014 data reviewed includes summaries and registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicates appropriate management of adverse events.   An 'Incident Management Form' is used to document all incidents that are referred to UCG head office.   There is an open disclosure policy. Resident files reviewed (five hospital and two rest home) provide evidence of communication with families following adverse events involving the resident, or any change in the resident’s condition. Family interviewed (three) confirm they are advised in a timely manner following any adverse event or change in their relatives condition.   Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).   ARC requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Written policies and procedures in relation to human resources management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (seven of seven) along with employment agreements, completed orientations and competency assessments. Criminal vetting is reviewed on five of the seven files, the exceptions are the FM and CSM who were employed prior to company policy being implemented that requires criminal vetting for all employees.  The FM is responsible for management of the in-service education programme and there is comprehensive evidence available indicating in-service education is provided for staff utilising various methods of delivery. A quality initiative was implemented to improve compliance with in-service education and documentation relating to this is reviewed during this audit. One of the projects aims is to deliver education in a manner that suits the individuals learning style/s. The methods of delivery utilised include completion of online education modules via an external provider; completion of the ACE education modules; provision of in-service education sessions at least three times a month; attendance at external education sessions; completion of questionnaires for staff who are unable to attend the in-service education sessions or if there is an issue that requires staff to update their knowledge; and provision of one-to-one education for staff. Evaluation of this initiative indicates the average time spent on education during the year has doubled from the previous year. As a result of the improvements to service noted as a consequence of this quality initiative one criterion (1.2.7.5) is rated continuous improvement.  Individual records of education are maintained for each staff member as are competency assessments. Education spread sheets as well as education records for each session and in-service education programmes are reviewed.  An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff advise they are 'buddied' for at least three days at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided (ie, the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation’s vision, values & philosophy).  All caregivers are required to complete the Health Education Trust ACE modules. It is UCG policy that all RNs are required to complete the ACE dementia education modules and evidence reviewed during this audit provides evidence that all RNs have completed the ACE modules as have all 17 caregivers.   An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed. Annual practising certificates are current for all staff who require them to practice.   Care staff interviewed (three care givers and three RNs working all shifts) 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.  ARC requirements are met. |

##### **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.

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

##### **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Education plans for 2013 and 2014, competency register and in-service register spread sheets are reviewed along with individual education records. The facility manager who is responsible for management of the in-service education programme is interviewed and discusses the various types of in-service education provided to best meet the learning style of the staff employed.    A quality initiative with aims, outcomes and summary relating to improving compliance with education is reviewed. This documentation describes the various methods used to deliver education as well as the successes attributed to each delivery method.   Education is provided via online learning modules, ACE Training, regular in-service education, attendance at external education, and via completion of questionnaires for staff who are unable to attend an in-service education sessions.  Staff interviewed advise they receive a lot of education on a regular basis. They also confirm that multiple methods are used to provide education and that they can choose the method that best suits them. |
| **Finding:** |
| There is comprehensive evidence that ongoing education is provided and is attended by staff. The facility manager recognised that staff have different learning styles and developed a quality initiative that was aimed at improving compliance with education. This quality initiative also recognises that shift workers, especially those working night shifts, and workers with young children do not always find it easy to attend education sessions during the day. Review of documentation associated with this quality initiative demonstrates the average time spent on training has increased and the attendance rates have increased. The facility manager during interview states the education is of a higher quality as it is tailored to the needs and learning styles of each staff member. |
| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a clearly documented rationale ('Policy For Service Management') for determining service provider levels and skill mixes in order to provide safe service delivery in place at Churtonleigh Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer'. ‘The Ultimate Care Group Rostering Tool’ is used by the facility manager to report to UCG head office on a weekly basis. Registered nurse cover is provided 24 hours a day. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager is on call after hours.   Caregivers interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is generally enough staff on duty to provide them with adequate care.  ARC requirements are met. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| New admission to Churtonleigh Lifecare have their information recorded usually on the day of admission and always within 24 hours of admission (seven of seven files reviewed). The residents' records contain information to safely identify the residents, are legible and dated. Integrated notes on the resident's progress are completed daily. These are dated with the time of entry and the designation of the staff member making the entry recorded. All current records sighted are integrated.  All records sighted are secure. Residents' current files are stored in a locked cupboard. Resident information is entered into both hard copy and electronic files (e.g. the resident register). The registered nurse deals with resident file content and administration staff enter in the financial details.   A standard format is in use for file documents and includes the residents’ admission agreement, admission form, general consent and identification of the General Practitioner (GP), service coordination assessment and enduring power of attorney (EPOA). The service is not responsible for NHI numbers.  The administrator keeps a register of past and present residents which includes details of name, NHI, DOB, GP and room number plus admission date and address, next of kin and date left service (including discharge address) and or deceased. This is also kept electronically.   Archived files are in a locked cupboard in a room with fire protection sprinklers. There is a hard copy ‘Archived Register’ which is kept with the archived records and documents residents name, NHI, DOB, admission date and discharge date. Archived notes are filed under the discharge date in alphabetical order.   All relevant ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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 1.3.1: Entry To Services **(**HDS(C)S.2008:1.3.1)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment whereby when the need for service has been identified, care is planned, co-ordinated and delivered in a timely and appropriate manner. Access and entry criteria are documented and communicated to residents and their family/whanau by local doctors, referral agencies, DHB hospital and local community groups. Service availability and information related to Churtonleigh Lifecare is available through the Service Coordination Agency, the local GPs, on site brochures and on the Eldernet and Ultimate Care websites. The admission and pre-admission documentation includes information about the services provided, its location, hours, how service is accessed, residents rights and responsibilities including a copy of the Code of Health and Disability Services Consumers’ Rights, the availability of cultural support, after hours or emergency contacts if needed and identifies the process if a resident requires a change in the care provided.   Prior to entry, the resident is assessed by Service Coordination Service (NASC) to ensure the resident requires service. Churtonleigh Lifecare has a good working relationship with the service coordination service, doctors and community agencies who are aware of the level of care offered and the process required to access that care. The service operates twenty four hours a day seven days per week.  The prospective resident information pack includes a copy of the Code of Health and Disability Services Consumers’ Rights, Residential Care Subsidy and loan brochure, Long Term Care for Residential Care brochure and information on Churtonleigh Lifecare.   If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the Service Coordination service. All enquiries are documented on a prospective resident enquiry form. Information packs are sent out or given to prospective residents when they call in. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Manager or Clinical Services Manager.  Seven of seven files reviewed contain completed assessments by the Service coordination service verifying placement is required. Admission agreements are signed and sighted in each of the seven of seven files. Admission agreements meet contractual requirements. Resident and family members interviewed confirm they were informed and involved in accessing the services they required.   The ARRC requirements are met |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare provides an environment, whereby a resident will only be declined entry if there is no vacancy or they do not provide the level of care required. In either of the above the resident will be referred back to the Service Coordination Agency.  Churtonleigh Lifecare has a clear process for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services. If appropriate an initial contact is made on behalf of the resident/family. The reason for declining entry is documented and kept on file (sighted). The admission agreement, describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility.   The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the first 24 hours of a residents’ admission to Churtonleigh Lifecare the Registered Nurse (RN) on each shift participates in the assessment process gathering data by completing the assessment tools, talking to the resident and family and observation. This serves as the basis for care planning over the next three weeks.   The long term care plan is completed by the RN allocated to that resident, within three weeks of admission and includes the collection of more detailed assessment data. The long term care plan directs the care required to meet the resident’s need and desired outcome. The assessment, care plan and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals. The care plan is evaluated every three months or as needs change to ensure the appropriate care is provided and the residents’ desired outcomes are being met.   Family contact is documented in the Family Contact Record, as sighted in seven of seven files reviewed (two rest home and five hospital). Residents and family/whanau are happy with the quality of care that is provided at Churtonleigh Lifecare as verified by interviews with seven of seven residents and three of three family/whanau members.  Medical assessment is conducted by the general practitioner (GP) within 24 hours of admission and the treatment programme required by the resident is documented. Ongoing medical review, by Churtonleigh Lifecare’s contracted GP or the residents own GP, is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. Evidence of this is sighted in seven of seven files reviewed.    Eight of eight RN’s practicing certificates, medication competencies and first aid certificates are sighted. Caregivers with experience, education and training in aged care and dementia (as evidenced by training records) provide most of the direct provision of care. The registered nurse acts as the resident’s case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care. A verbal handover by the RN that includes a printed recent update of each resident occurs at the beginning of each shift to ensure all staff is familiar with the resident needs (observed). The education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks and kitchen assistants have food safety training (records sighted) The contracted physiotherapist and podiatrist provide services to the residents. The annual practising certificates (APCs) are sighted for all staff and contracted staff that require an APC.   Health professionals delivering the daily care to residents, write in the resident's progress notes at the end of each shift. Handover of resident status is via progress notes and a verbal report at the beginning of each shift, as observed. Resident notes are integrated and demonstrate input from a variety of health professionals and is responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Each month a case review of a resident is presented to the clinical staff by an RN, this is an in depth presentation covering the resident’s illness, problems and treatments. The critical examination of the case enables a more diverse understanding of the resident and the reasons behind treatments. Six of six clinical staff interviewed made reference to how valuable each session is. Staff and resident turnover at Churtonleigh Lifecare is low, assisting in the provision of continuity of care.  Re-assessment, review and evaluation of residents and their needs is ongoing, by a RN and occurs as needs change or every three months. Comprehensive evaluation is sighted and includes consultation with the resident, the GP, family and/or advocate, to determine the resident's degree of progress towards the desired goals and initiated changes where progress differs from that expected. Changes to the plan, are evidenced to involve the resident and/or family if requested, by signage on the care plans documented communication records of family contact, phone calls or emails.   Timely access to other health providers is evident in seven resident's file reviewed. An initiative is in place at Churtonleigh aimed at minimising disruption to residents and unnecessary admissions to CCDHB when medical management could occur at Churtonleigh. A geriatrician visits every three months and reviews any residents of concern, in addition to Churtonleigh staff having direct phone access to talk to the geriatrician. In addition to this, the liaison nurse is available to assist staff and address knowledge deficits in nursing management. Resident care and outcomes have improved in the last year by a reduction in admissions to the DHB by 50%, as verified by a review of documentation relating to analysis of the project, admissions, resident file (three) reviews verifying documented consultation by the Geriatrician, interviews with one of one GP, the clinical services manager and facility manager.    The ARRC requirements are met.  Tracer methodology 1 – Rest Home –  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology 2 – Hospital –  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| An initiative is in place at Churtonleigh aimed at minimising disruption to residents and unnecessary admissions to Capital Coast District Health Board (CCDHB) when medical management could occur at Churtonleigh. A Geriatrician visits every three months and reviews any residents of concern, in addition to Churtonleigh staff having direct phone access to talk to the Geriatrician and the liaison nurse is available to assist staff and address knowledge deficits in nursing management. |
| **Finding:** |
| Implementation of a coordinated approach between CCDHB geriatric services and Churtonleigh Lifecare has resulted in less stress to residents and a reduction in admissions to CCDHB by 50% when compared to the previous 12 months. Sighted supporting documentation and interviews with the GP, clinical services manager and facility manager are all satisfied with the process and confident it produces the desired outcome. |
| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| New residents admitted to Churtonleigh Lifecare, are assessed using clinical assessment tools included on the resident's care plan. During the first 24 hours of admission the registered nurse on each shift assesses the resident to identify the resident’s immediate needs and requirements.   The information gathered informs the care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested. Over the next three weeks, the RN allocated to the resident undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals, behaviour and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care planning. This is verified by interviews with seven of seven residents, three of three family/whanau and six of six clinical staff.    The assessment is reviewed three monthly as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A pharmaceutical review is undertaken every three months.   Seven of seven residents and three of three family/whanau interviews, verify residents and family are included and informed of all assessment updates and changes.  Six of six clinical staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs. Assessment documentation is verified in two of two rest home, five of five hospital files and 14 of 14 medication charts sighted.   The ARRC requirements are met. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care plan developed in consultation with the resident and/or family/whanau, documents the plan of care identified by initial, on-going individual assessments, and identifies appropriate, resident guided interventions to enable the resident to meet their needs, goals and desired outcome.  Residents have one set of clinical notes in which all providers involved with the resident’s care use to document. Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book, handover sheet and the resident's care plan. Care plans are evaluated three monthly or more frequent as the resident's condition dictates.   Information from the assessment process informs the allied services of residents’ need. The kitchen is informed of the need regarding nutrition and the activity assessments inform the activities officer of interventions required in the activities programme.   The staff education records sighted for Churtonleigh demonstrate that staff receive appropriate training both onsite and on line. Training records evidence education that includes infection control, wound care, end of life care, restraint minimization and safe practice, elder abuse and neglect and management of challenging behaviour. The registered nurses (RN’s) participate in education offered by CCDHB and others specialist services and all RN’s have completed the ACE dementia training. (Refer 1.2.7.5).  Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. Timely access to other health providers is evident in three of the seven residents' files reviewed, where specialist input is required.  The ARRC requirements are met. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care and services at Churtonleigh Lifecare are delivered in a safe and respectful manner. New residents are welcomed and orientated to Churtonleigh Lifecare (confirmed at interview with seven of seven residents and three of three family/whanau). The seven of seven care plans reviewed, document the care and interventions required to meet residents' goals, assessed needs, desired outcomes and current best practice standards, as identified in the assessment process. Interventions are detailed and consistent with services required .  Interviews with three of three family/whanau members expressed satisfaction with the care, the respect shown to them and the quality of the food that they or their relative receives. There are sufficient supplies of dressing equipment that complies with best practice guidelines and continence aids to meet the resident’s needs (sighted).  The contracted GP who attends to most of the residents at Churtonleigh is interviewed and is complimentary of the services offered by Churtonleigh. They are responsive to his requests and notify him appropriately of any concerns. He verifies a reduced need for admission to CCDHB with access to the geriatrician (refer 1.3.3.4).  Appropriate links with the CCDHB (refer 1.3.3.4) are maintained. The CCDHB clinical nurse specialist and hospice nurses are available for advice, consultation and review. There is evidence of referrals to specialist services and specialists noted in consumer's files. A palliative care education module is being offered onsite for registered nurses and senior caregivers by an educator from the hospice. Podiatry and physiotherapy services offered on site. The geriatrician visits three monthly. Referral documentation in resident’s files is sighted, where specialist input is required. The Clinical Services Manager interviewed describes the transfer procedure and explains that resident’s care plans summary and medication charts are photocopied and accompany the consumer when transferred.   The ARRC requirements are met. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Trained diversional therapists work five days per week at Churtonleigh Lifecare. One diversional therapist works Mon/Tues 8.30-12.30 and Wed-Fri 10-3pm and on Wednesday another trained diversional therapist assists. On admission the resident’s profile is filled out with the family/whanau and resident to establish interests and set goals. Residents are assessed to ascertain their needs and appropriate activity requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The activities plans sighted match the skills, likes, dislikes and interests evidenced in the activity assessment data The planned monthly activities programme offered is based on resident need and requirements and incorporate physical, intellectual, spiritual and sensory activities as well as cooking and hairdressing. Activities reflect ordinary patterns of life and include a visit from the local school once a week to do craft activities and use iPads, pet therapy once a week, monthly church service and group discussions and an outing once a week where the residents go out in a van. Visiting entertainers attend twice a month. There is an annual shopping trip to North City Plaza.   Individual activity assessments are updated or reviewed three monthly with a monthly summary of the residents response to the activities and participation recorded, as sighted in seven of seven files reviewed. The goals are developed with the resident and their family, where appropriate as verified by seven of seven residents and three of three family members interviewed.  The ARRC requirements are met. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Evaluation of resident care at Churtonleigh Lifecare is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes .  Formal care plan evaluations are conducted at least three monthly or as needs change. Evaluations as sighted in two of two rest home and five of five hospital files is comprehensive and is undertaken to measure the degree of achievement or response of each resident related to their goals. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan.  A short term care plan or changes to the long term care plan is initiated for issues, such as infections, wound care, changes in mobility and the resident’s general condition. There is evidence in the residents integrated notes that family/whanau are involved in the evaluation process and this is also verified in seven of seven resident and three of three family/whanau interviews  The RN undertakes and documents all care plan evaluations, at least every three months (sighted in all seven of seven files reviewed). Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.  Customer satisfaction surveys of residents, family/whanau and staff verify satisfaction with the service.   The ARRC requirements are met. |

##### **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Consumer support for access or referral to other health and/or disability service providers is facilitated to meet consumer need. Churtonleigh has direct access to advice from the Geriatrician at CCDHB (refer 1.3.3.4). If the need for other services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. The resident and the family are kept informed of the referral process.   Residents are supported to access other health and/or disability support services as required or requested. The facility has access to a van that can escort residents to appointments. Residents and their families are given a choice and advised of their options to access other health and disability services where indicated or requested. A record of this is maintained. If the need for other services are identified these services are sought, with the resident and/or family supported to do so. Residents are given a choice of GP when they are admitted. Most residents use the contracted GP. He visits weekly and offers a 24 hour/seven day a week service.   Any non-urgent referrals sent, are followed up on a regular basis by the registered nurse or the GP. Residents and families are kept informed of the likely wait times. Where possible a family member accompanies the resident. Acute/urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed.   The ARRC requirements are met |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Exit, discharge or transfer from Churtonleigh Lifecare is managed in a planned and co-ordinated manner that keeps the resident family/whanau fully informed. There is open communication between all services, the resident and the family/whanau. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. There is a specific transfer/discharge form, that records all the relative information needed when transferring a resident. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes. The resident's family/whanau will be notified of the upcoming appointment and will be invited to attend and assist, unless the resident requests otherwise.   The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents at Churtonleigh Lifecare receive their medicines in a safe and timely manner that complies with legislation and safe practice guidelines which are consistently followed. Medicines are dispensed and delivered by the pharmacy in the Medico Pak delivery system. All medicines are prescribed by the GP. Each resident has an individual medicines profile that includes a photograph and any documented allergies, medicine prescription form, an individually dispensed Medico Pak for their medicines and medicine signing sheets.  The received medicines are checked by the registered nurse (RN) for accuracy when new sachets or medicines are delivered. There is a pharmacy box in the medicines room for the pharmacist to pick up medicines being returned to the pharmacy.    The safety of residents, visitors, staff and contactors is maintained through appropriate storage and access to medicines. There is locked secure medicine trolley to store medicines in use. Storage of stock medications is in a locked cupboard. Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range   Interview and observation of the RN undertaking medicine administration on the day of audit verified awareness of the role and responsibilities related to all aspects of medicine management and the regulations concerning administration of controlled drugs. Contents of the medicine pack are observed as checked against the medicine order.  Medicine charts reviewed have each medicine signed for when dispensed (or the reason why the medicine was not given) recorded on the signing sheet. There is a specimen signature register maintained for all staff who administers medicine. The medicine charts reviewed have allergies and sensitivities recorded in a prominent position, a recent photograph of the resident for identification. Each medicine is signed individually by the GP, records date of the order, medicine, strength, dose, time, route, frequency and duration. Medicine reviews by the GPs are recorded on the medicine chart at least three monthly.  Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. Churtonleigh Lifecare has eight medication errors recorded last year (2013). Analysis of the medication error incident forms by the manager, notes errors relate to medications being observed to have been taken, but the resident removing it later and throwing it on the floor. Corrective actions are implemented and documented. To date analysis has found actions effective. The implementation, of the medication module of the “Releasing Time to Care” initiative in January this year, is hoped to further identify areas of risk to be addressed, before errors occur(refer 2.3.7)  Transdermal patches are in use and guidelines are followed as sighted.  There is one resident on Warfarin. Documentation sighted shows evidence of regular ‘INRs’ and the dosage dispensed complies with results and the GP’s written instructions.  Insulin is only administered by RN’s. Currently there is no one on insulin at Churtonleigh Lifecare.   No residents are self-administering medications at Churtonleigh Lifecare. Standing orders are not used. Only medications individually prescribed to residents are dispensed.  Documentation is sighted verifying RN competency in medication management. Competency is reviewed by the manager or clinical services manager yearly. Approved healthcare workers are certified as competent to check medication but not to dispense (documentation sighted).    The ARRC requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Lifecare has a planned menu that changes seasonally (sighted) and is reviewed by the dietician within the last two years. Evidence is sighted that the menu has been adjusted according to the dietician’s recommendations. The nutritional requirements of the menu are based on the Ministry of Health (MOH) food and nutritional guidelines for older people. The facility has ongoing access to a dietician and a process for referral. Churtonleigh Lifecare has policies and procedures relating to food and nutrition services that are reviewed at least two yearly.  All food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered twice a week, depending on need and availability. Meats and fish are ordered twice weekly and dry goods weekly. When food is delivered it is checked for ‘use by date’ and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Freezers are defrosted every month. A separate freezer contains three days of emergency supplies of prepared frozen foods (muffins, precooked meals etc.). This is rotated and replaced every three months and documentation of this is sighted.   Temperature records are reviewed with the cook and are within accepted parameters. Meal temperature charts record meals are tested when cooked and when it has been sitting in the Bain Maree prior to serving. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days. A cleaning schedule is sighted and is signed off when attended to each day. A preventative maintenance programme for preventing rodents is in place and sighted. Churtonleigh Lifecare has a “Standard of Excellence” kitchen food hygiene certificate, awarded by the Wellington City Council (sighted) which expires in June 2014, when a new inspection will be undertaken.  The cook is a trained chef and has worked at Churtonleigh Lifecare for 13 years. The facility provides for annual on-line training in nutrition and food related aspects of resident care for kitchen staff, registered nurses and care givers, as sighted in training records and verified through interviews with six of six care staff and kitchen staff. Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings.   There is evidence to support sufficient food is ordered and prepared to meet the residents’ recommended nutritional requirements. Between meal snacks are available. Evidence of resident satisfaction with meals is sighted in customer satisfaction surveys and verified by interviews with seven of seven residents and three of three family/whanau members. Sufficient staff are on duty in the dining room at meal times to ensure appropriate assistance is available and this is observed. The dining room is clean, warm light and airy to enhance the eating experience.  A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Dietary profiles are sighted on a white board in the kitchen and make references to special dietary needs/likes/dislikes/allergies.   The ARRC requirements are met |

##### **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.

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

##### **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.

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

##### **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.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets are available throughout the facility and are accessible for staff. The Hazard Register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in February 2013 and is scheduled for March 2014. Monthly visits are undertaken by an external representative who reviews kitchen, cleaning and laundry processes. Copies of these reports are reviewed during this audit.  A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks are viewed in sluice rooms.   Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. A sluice room is available for the disposal of waste and hazardous substances.  ARC requirements are met |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.  A maintenance person is employed for 16 hours a week and is interviewed during this audit. Also interviewed is the UCG property manager/maintenance manager. The maintenance persons interviewed confirm there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires on 26 October 2014 is clearly displayed.  A visual inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to a high standard. Corridors are wide and allow residents to pass each other safely; safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (eg, safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes).  Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment (e.g. hoists competency). This was confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.  Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. They also confirm during interview they are able to move freely around the facility and that the accommodation meets their needs.   ARC requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| With one exception, bedrooms provide single accommodation and have wash hand basins. Ten of the bedrooms have shared ensuite facilities and there is an adequate number of communal toilet and shower facilities available throughout the facility.   Visual inspection provides evidence that toilet, shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at two monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).  All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and wash basin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. |

##### **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection provides evidence that adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Several of the bedrooms have double leaf doors and are large enough to allow for easy access for mobility aids. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection provides evidence that adequate access is provided to lounges and the dining room. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Cleaning policy and procedures, and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons. All linen is washed on site in the laundry and although the laundry is on the small side, there is adequate dirty / clean flow. The laundry person interviewed describes the management of the laundry including transportation, sorting, storage, laundering, and return to residents.  Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed, along with monthly external contractor reports. The cleaner was interviewed and describes cleaning processes. Visual inspection of the facility evidences: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste (ie, sluice room; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas). Residents interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of satisfaction surveys completed in December 2013. ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are reviewed. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.   New Zealand Fire Service letter (dated 21 March 2000) advising evacuation scheme approval is sighted. The last trial evacuation was held on 07 January 2014.  All registered nurses and activities personnel are required to complete first aid training. There is at least one designated staff members on each shift with appropriate first aid training.   Staff interviews and review of staff files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled evidences current training regarding fire, emergency and security education.   Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.   A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.   A visual inspection of the facility evidences emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.   There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas (eg, bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond to it in a timely manner. This is confirmed during review of the satisfaction survey completed in December 2013.  ARC requirements are met |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.  Residents interviewed confirm the facilities are maintained at an appropriate temperature.  ARC requirements are met |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Churtonleigh Life care’s’ restraint policy is based on the Restraint Minimisation and Safe Practice Standard NZS 8134.2008. The policy identifies that restraint is only used as a last resort after alternative approaches to care have been trialled and the benefits and risks of restraint have been considered. Restraint can only be initiated by an RN and at the request of the family or resident. Where restraint is practiced all residents will have the following documentation within their file:  Restraint Assessment Form – Alternative Management Strategies (i.e. de-escalation techniques)  Restraint Consent Form  Restraint Approval group Form Restraint Monitoring – Daily Intervention Form  Restraint Evaluation & Review Form.  Prior to restraint being approved an assessment is undertaken. The risk assessment identifies if pain relief, comfort measures, therapeutic touch have been tried and what the outcome was. The assessment also covers cultural aspects of care. If none of the above has been successful an application for restraint use being initiated is completed.   Initial assessments for enablers are discussed with the resident, family/whanau, the GP and the RN. 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.  A rest home resident who has an enabler - a bedside to assist turning when in bed, has requested it and has signed their own consent for use form. As confirmed by the restraint coordinator residents who use enablers have them in place to allow the resident to maintain maximum independence. The resident is mentally alert and can ask for assistance appropriately. Enablers are reviewed three monthly by the restraint coordinator in consultation with the resident and family/whanau as appropriate and treated as other restraints for the purpose of review and signing updates. This is confirmed in documentation and the file review sighted. Three of three files reviewed of residents with restraints identified documentation as per policy requirements.  Churtonleigh Lifecare’s policy identifies that appropriate education and competency of staff is critical to the minimisation and safe use of restraint.  As confirmed by the restraint coordinator and in staff education records sighted, restraint education is included in the orientation and on-line as a self-directed learning pack and part of the regular on-going in-service education. The last in-service education and restraint competency assessment is conducted in August 2013. Restraint minimisation education includes alternatives to restraint, and de-escalation techniques. Interviews with three of three RNs and three of three caregivers confirm staff awareness and knowledge related to safe restraint use.   The restraint register (sighted) evidences a recent decrease in restraint use at Churtonleigh Lifecare. All residents using restraint at Churtonleigh Lifecare have either requested it themselves or it has been requested by families. This is evidenced in three of three files reviewed whereby documentation verifies residents requested restraint and is confirmed by resident or family interview. The request for restraint (bedsides) relates to fear of falling out of bed. A recent purchase of perimeter guards for mattresses has provided three residents with the security that has enabled them to allow the restraints to be removed.   Churtonleigh Lifecare hopes to further minimise the use of restraints by offering the nine residents using restraints, and their families alternatives that may mitigate their fears.  The ARRC requirements are 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.

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint is used for safety reasons only. Approval for the use of restraints at Churtonleigh Lifecare must be given by the Restraint Approval Group (Clinical services Manager, Manager, GP, resident/family, cultural advisor, restraint co-ordinator and the physiotherapist). For each case of restraint approved the approval group will ascertain the need for staff education, family discussion, type of restraint, monitoring and review requirements and how often the equipment has to be maintained. This is documented as part of the approval process. Where approval for restraint is granted, the restraint co-ordinator, clinical services manager, resident/family and GP, must sign the ‘consents for restraint’ form.  The restraint co-ordinator is responsible for leading the approval groups recommendations to keep the resident safe and keep up to date with best practice in addition to:  i) Reviewing restraint procedures  ii) Identifying why restraint is being used and taking action to reduce this  iii) Working with the MDT to reduce the use of restraint  iv) Assisting with staff training in restraint minimisation and safe practice   The role of the restraint coordinator is clearly identified in the role description sighted. During interview the restraint coordinator verbalised her knowledge and understanding of safe restraint use and verified approved restraints. Approved restraints identified in policy include:  i) Waist belt or sit safe enabler. ii) Table top chairs  iii) Bed Rails, with bedside protectors and the height of the bed at its lowest  iv) Lazy boy chairs.  Every resident commenced on restraint is reviewed by the GP after 24 hours of the commencement and thereafter three monthly.   Processes for the approval of restraints, use, monitoring and review are understood by staff as verified by compliance with documentation in three of three files reviewed of residents with restraint and six of six clinical staff interviews.  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The RN or the restraint coordinator at Churtonleigh Lifecare undertakes assessment processes prior to restraint approval which are clearly documented. Family/whanau are kept involved in all restraint use decisions and updates. The assessment includes:  - consideration of the individual, significant events in their life that might influence their care or behaviour  - their general care needs and how best to meet these  - specific cultural needs and how best to meet these  - the resident’s desired outcomes and goals in relation to care  - identification of changes in behaviour which if recognised early and supported by alternative care approaches would eliminate or minimise the requirement for restraint  - the most appropriate and least restrictive method of supporting the resident while ensuring their personal safety and the safety of others is maintained  - Consideration of the resident’s perception of the situation and the need for restraint. - the impact of restraint on the consumer and their family  - that the dignity and rights of restrained residents are considered at all times   All assessments are discussed with the resident and family/whanau. Individual risks are identified, documented and the strategies to minimise these are communicated to the resident and/or family/whanau. This is confirmed during interview with three of three residents. Three of three files reviewed evidence documentation of restraint assessment.  Churtonleigh Lifecare ensures all procedures in place are continually monitored by the restraint approval group. All restraint is approved prior to use following appropriate assessment processes being completed. Monitoring is determined by the identified risk of restraint use.  There is a restraint register which identifies all restraint/enabler use.   The ARRC requirements are met |

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

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

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

Services use restraint safely

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Every resident using a restraint is monitored 1-2 hourly, dependent upon risk level and as determined by the restraint approval group, while that restraint is in place. Restraint is reviewed at monthly quality and staff meetings as confirmed in meeting minutes sighted. Three monthly reviews are undertaken by the restraint coordinator. (Documentation sighted). Monitoring is required to promote the consumer’s physical safety, maximise comfort and ensure all other care/support and treatment needs are met. This will include, but is not limited to, the provision of fluid and nourishment, personal hygiene and toileting arrangements, suitable clothing, medications, exercise and activity as appropriate. Individual resident monitoring requirements are undertaken according to risks identified during the assessment process. Monitoring forms in three of three file reviewed, identify this is fully implemented by the service.   Three of three caregivers and three of three RN interviews confirm their understanding of monitoring requirements to be undertaken according to what is shown on the resident's care plan. Consent for restraint procedures are sighted and undertaken as described, in three of three resident folders who require restraint. Restraint is only used for safety reasons as a last resort and of alternative interventions are well documented, such as the use of extra low beds. The restraint register sighted establishes sufficient information to provide an auditable record of restraint use.   Policy identifies that appropriate education and competency of staff is critical to the minimisation and safe use of restraint. Orientation records evidence restraint minimisation training is part of orientation. Staff education records sighted show restraint de-escalation techniques and alternatives to restraint and challenging behaviour education taking place in August 2013, when restraint competency assessments were also performed. This is verified in interview with six of six clinical staff.  The ARRC requirements are 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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| **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.

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Progress notes recorded by staff on each shift, and more frequently when necessary, include evaluation of restraint use. The post commencement review is conducted after 24 hours and three monthly thereafter.  The Restraint Evaluation and Review Form is used to document an evaluation of the restraint process, and whether the goals for the resident have been met, by the interventions implemented. Family/whanau and the resident are involved in the review process. Three monthly evaluations sighted evaluate the effectiveness of restraint use and associated interventions. Family/whanau discussions with the restraint coordinator are clearly documented. The restraint co-ordinator confirms she would undertake reviews sooner as required. Three of three file reviews identify that the resident and family/whanau are involved in the evaluation process and sign consent for on-going restraint use as appropriate. This is verified by interview with three of three residents and their families, who use restraint.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is able to demonstrate that monitoring and reviews are conducted related to the use of restraint/enablers. The approval group monitors the use of restraints and reviews all restraints six monthly. Review includes the type of restraint in use, the progresses being undertaken towards becoming a restraint free environment such as the use of low beds and perimeter guards, adverse outcomes, compliance with standards, restraint approval group meeting frequency, staff competency and education. Findings and recommendations are used to improve service provision and resident safety. Restraint is monitored, trended and benchmarked. Churtonleigh Lifecare is aware the restraint use is relatively high, as verified by interview with the clinical services manager. The Restraints Minimisation Standards Meeting minutes 16 December 2013, sighted. Notes no injury has occurred as a result of bedside use. Five residents have discontinued restraint; three of those are now using perimeter guards. Families and residents have identified they are nervous about having bedsides removed. The review has identified an increase in attendance at staff training (refer 1.2.7.5) and that monitoring forms are well documented. The facility has reduced restraint by five in the past six months.  ARRC requirements are met. |

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Ultimate Care Group (UCG) Limited corporate infection control management systems are in place at Churtonleigh Lifecare along with infection control policies and procedures to guide staff on all matters relating to infection control. The infection control (IC) policies and procedures meet the needs of the organisation and provide information and resources to inform the staff on infection prevention and control.  Care staff interviewed confirm the infection control policies and procedures provide them with adequate guidance. The infection control programme has been recently reviewed and approved by the UCG clinical advisory group in August 2013. The delegation of infection control matters throughout the organisation is clearly documented along with an infection control (IC) co-ordinator job description. The facility manager (FM) is the IC Co-ordinator. The job description for IC co-ordinator sighted on the FM / IC co-ordinator’s personal file and outlines their responsibilities. The FM / IC co-ordinator is interviewed and confirms their input into infection control management. They also describe review of infection control matters at the facility and confirm the governing body receives regular reports on infection related issues by regular reporting systems as well as via the UCG electronic database.   FM / IC co-ordinator advises there have been no outbreaks at the facility since the last audit.  Visual inspection provides evidence that staff provide infection management precautions.   ARC requirement is met |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff. The IC co-ordinator / FM is a registered nurse with the relevant skills and resources necessary to achieve the requirements of this standard. During interview the IC co-ordinator / FM report they are able to access laboratory personnel, GPs and other health care professionals for infection control advice as required. Management and staff have access to relevant and current information, which is appropriate to the size and complexity of the organization. The IC co-ordinator / FM reports ongoing in-service education was provided in December 2013 by personnel from the local district health board. The facility has RN cover 24/7 and care staff interviewed confirm the FM, CSM or RNs are available for management of infection control issues or advice as required. Care staff also confirm they have access to policies, procedures and resources to manage infection prevention and control.  ARC requirement is met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain information of an appropriate level and are readily accessible to all personnel. UCG policies and procedures are developed and reviewed regularly in consultation with relevant service providers. The policies and procedures identify links to other documentation in the organisation (e.g. health and safety, quality and risk).   The regional operations manager, FM and the CSM advises the UCG clinical advisory group are responsible for management of review of policies and procedures, including the infection control programme and associated policies and procedures. The CSM is a member of the clinical governance group.  Staff interviewed confirm infection control policies and procedures are readily available for them.  ARC requirements are met. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection control education is provided to staff as part of their initial orientation. The FM / IC co-ordinator, CSM, RNs and care staff advise the RNs provide one-to-one education as required.   Infection control education was provided in June and December 2013 by personnel from the local district health board as well as via online learning modules. Training records and education spread sheets indicates attendance by 38 members of staff at these sessions provided by the DHB.   The IC co-ordinator / FM advises infection control education is provided for residents on an as needed basis. The FM / IC co-ordinator’s personal file is reviewed and evidences attendance at several infection control education sessions (11 hours in the last 12 months).  ARC contract requirement is met. |

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

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

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

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

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

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

#### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Review of documentation provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organisation.   All infections are recorded on an ‘Infection Control Summary Report Form’ which is a register of infections. Also reviewed are ‘Clinical Indicator Monthly Summary – Infection Control Report’ monthly reports. Residents with infections have an 'Infection Data Care Plan' completed, which is a short term care plan to address the infection. These are reviewed on resident’s files for residents who have had infections.  Results of surveillance are reported on the UCG electronic database. Collated reports with analysis of this infection surveillance data are reviewed. Clinical indicators are reported monthly to the quality meetings and to the two monthly infection control/ health and safety meetings and via the 'Weekly & Monthly Reports' to the governing body.   Staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RNs, and daily handovers. They also report this infection surveillance information is made available for them during hand over and at staff meetings. Staff also report copies of meeting minutes and graphs are in the staff room.  Infection control audits are completed as part of the internal audit programme. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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