

# Presbyterian Support Services (South Canterbury) Incorporated - Margaret Wilson Complex

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Current Status: 27 January 2014

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

## General overview

Margaret Wilson complex is part of the Presbyterian Support South Canterbury (PSSC) service. The service provides rest home, hospital - geriatric/medical and disability services (young person's disabled) for up to 70 residents. On the day of the audit there were 67 residents.

The nurse manager at Margaret Wilson has been in the role for one year and is supported by the PSSC Elder Care Manager and the Chief Executive Officer (CEO).

The service has addressed five of the nine shortfalls from the previous certification audit relating to document control practices, closing the quality loop, clinical documentation following incidents, management of training records, and signing of medication orders.

Further improvements continue to be required around recording residents personal belongings, addressing sexuality and intimacy in care planning, care plan interventions, and safe chemical management.

This surveillance audit identified improvements required around utilising short term care plans and aspects of medication management.

## Audit Summary as at 27 January 2014

Standards have been assessed and summarised below:

### Key

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

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

#### Consumer Rights as at 27 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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#### Organisational Management as at 27 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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#### Continuum of Service Delivery as at 27 January 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### **Safe and Appropriate Environment as at 27 January 2014**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### **Restraint Minimisation and Safe Practice as at 27 January 2014**

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### **Infection Prevention and Control as at 27 January 2014**

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Presbyterian Support Services (South Canterbury) Incorporated
<b>Certificate name:</b>	Presbyterian Support Services (South Canterbury) Incorporated - Margaret Wilson Complex
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Margaret Wilson Complex
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	<b>Start date:</b> 27 January 2014 <b>End date:</b> 27 January 2014
<b>Proposed changes to current services (if any):</b>	

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	67
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## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	5
<b>Technical Experts</b>	XXXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	2
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	14	Total audit hours	38
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Number of residents interviewed	9	Number of staff interviewed	11	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	80	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Wednesday, 5 March 2014

## Executive Summary of Audit

### General Overview

Margaret Wilson complex is part of the Presbyterian Support South Canterbury (PSSC) service. The service provides rest home, hospital - geriatric/medical and disability services (young person's disabled) for up to 70 residents. On the day of the audit there were 67 residents; 39 rest home, eight residents under disability contracts and 20 hospital level care residents.

The nurse manager at Margaret Wilson has been in the role for one year and is supported by the PSSC Elder Care Manager and the Chief Executive Officer (CEO).

The service has addressed five of the nine shortfalls from the previous certification audit relating to document control practices, closing the quality loop, clinical documentation following incidents, management of training records, and signing of medication orders.

Further improvements continue to be required around recording residents personal belongings, addressing sexuality and intimacy in care planning, care plan interventions, and safe chemical management.

This surveillance audit identified improvements required around utilising short term care plans and aspects of medication management.

### Outcome 1.1: Consumer Rights

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

Complaints processes are implemented. Complaints and concerns are actively managed and well documented. Previous shortfall relating to recording of personal belongings has been addressed and monitored. Further improvements are required relating to documenting residents sexuality and intimacy needs in long-term care plans.

### Outcome 1.2: Organisational Management

PSSC Margaret Wilson Rest Home has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with other similar aged care facilities. Corrective actions are identified and implemented. Documents are controlled and old documents archived when new policies are introduced. The service has made improvements in these areas.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. The service has addressed and monitored previous finding relating to care plans reflecting changes following incidents and accidents.

There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-

service education programme covers relevant aspects of care and support. The service has addressed and monitored previous shortfall related to maintaining education records.

The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

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

A registered nurse is responsible for each stage of service provision. Residents and relatives are involved in planning and evaluating care and communication with family is documented. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Care plans are individualised, however improvements are required whereby interventions are documented and goals and objectives are developed for identified needs and documented in the integrated care plan. They are evaluated at least three to six monthly or more frequently when clinically indicated and assess progress towards goals. Short-term care plans are available for short term changes in health status, however short term care plans are not always documented for acute issues. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. Residents have a choice in their level of participation. There are comprehensive medication management policies. There are improvements required in relation to medication competencies completed for all staff administering medications, weekly stock takes and completion of signing administration sheets. Meals are prepared by contractors Alliance Catering NZ. There are food service policies and procedures and the menu is designed by a registered dietitian. A dietary profile of residents is developed on admission and food preferences are identified.

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

The service has a current building warrant of fitness, which expires 1 June 2014. An improvement is required around chemical labelling and storage.

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

Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. A restraint register records all residents with restraint or enablers. There are currently no residents requiring restraint. Ten hospital residents and four young persons disabled unit residents have enablers in the form of bed rails and one resident with a lap belt. Policy states that the use of enablers is voluntary, requested by the resident.

### **Outcome 3: Infection Prevention and Control**

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

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	14	0	2	3	0	0
<b>Criteria</b>	0	38	0	2	4	0	0

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

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Of the six files reviewed (three rest home, two hospital and one YPD), none of the six resident care plans reflect that sexuality and intimacy needs documented.	Include sexuality and intimacy documentation in integrated care plans	90

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Three of three rest home, two of two hospital and one of one young disabled hospital files identified goals/objectives and interventions are not documented in the daily care plan and integrated care plan for all identified issues and needs e.g. (i) Resident in the hospital with facial palsy (January 2014) did not have any specific intervention for this acute episode, there were gaps in resident monthly monitoring of weight, sexuality and intimacy was not covered in care plan. (ii) One hospital resident receiving insulin medication had no	Ensure that the daily care plan and integrated care plans capture all identified needs and issues and that goals/objectives, and interventions are documented.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				documented needs in regards to management of his diabetes. (iii). Rest home resident with a head laceration following a fall was receiving no neurological monitoring post injury. (link 1.2.4.3). One hospital and one rest home file identified there were gaps in weight management.		
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Short-term care plans are available; however they are not always used to document short-term acute issues. E.g. (i) There was no STCP written for a rest home resident suffering with shortness of breath and swollen legs and (ii) No STCP written for rest home resident with acute	Ensure that STCP are documented for all acute issues when progress is different to what is expected.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				cellulitis and on another occasion same resident suffered an acute cholecystitis.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	(i) It was noted that three of 12 medication signing sheets reflect a failure to include a signature after medication administration; (ii) Two eye drop containers on the hospital medication trolley reflect no date and time of opening on the container; (iii) weekly controlled drug stock checks have not been conducted; (iv) controlled drug administration records do not evidence two staff	(i) Ensure that all medications administered are signed for; (ii) ensure that eye drop medications are dated at time of opening; (iii) conduct weekly controlled drug checks as per guidelines; (iv) ensure that controlled drug administration sheets evidence two staff signatures.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				signatures.		
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	It is noted that annual competency for caregivers has not been maintained and that registered nursing staff have not completed medication competency.	Ensure that all staff with medication administration responsibilities are assessed as competent to do so.	60
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.6.3	Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Moderate	Not all bottles containing chemicals were clearly labelled. The sluice room is unlocked and two bottles with cleaning chemicals were on the bench.	Ensure chemicals are clearly labelled and stored correctly.	30

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Previous audit identified a shortfall around implementing policy relating to residents personal belongings. The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff interviewed (one nurse manager, one registered nurse team leader, two registered nurses, and five caregivers) are able to describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. Discussions with nine residents (three rest home, four hospital and two young persons disabled –YPD) and two relatives identified that personal belongings are not used as communal property. The staff were respectful of entering a resident's room and gained permission before doing so. A new policy has been developed and is implemented as evidenced in one recent resident admission. A new property list form is completed for all new admissions as evidenced in one recently admitted residents' files. This is an improvement from the previous audit. Previous audit finding criterion 1.1.3.5 around a lack of documentation in the resident integrated care plan addressing sexuality and intimacy. Sexuality, intimacy and sexual abuse training was provided on 14 March 2012. The sexuality and intimacy guidelines (SPM.CR.16) include guidelines for both appropriate and inappropriate intimacy and behaviour. The policy includes definitions, guidelines, appropriate sexual activity, and inappropriate sexual activity. Residents interviewed advised that staff are responsive to their values and beliefs and that the Eden philosophy of resident centred care is implemented. However, of the six files reviewed, (three rest home, two hospital and one YPD); none of the six resident care plans reflect that sexuality and intimacy needs documented. This remains an improvement from the previous audit.

**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.

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

**Criterion 1.1.3.2 (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Sexuality, intimacy and sexual abuse training was provided on 14 March 2012. The sexuality and intimacy guidelines (SPM.CR.16) include guidelines for both appropriate and inappropriate intimacy and behaviour. The policy includes definitions, guidelines, appropriate sexual activity, and inappropriate sexual activity. Residents interviewed advised that staff are responsive to their values and beliefs and that the Eden philosophy of resident centred care is implemented.
<b>Finding:</b> Of the six files reviewed (three rest home, two hospital and one YPD), none of the six resident care plans reflect that sexuality and intimacy needs documented.
<b>Corrective Action:</b> Include sexuality and intimacy documentation in integrated care plans
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Nine residents and two family members report they were welcomed on entry and were given time and explanation about the services and procedures. Resident/relative meetings occur monthly. The nurse manager is readily accessible, confirmed in interviews with five caregivers, residents and relatives. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term residential care in a rest home or hospital – what you need to know" is provided to residents on entry. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The family members interviewed state that they are always informed when their family member's health status changes or of any other issues arising. Evidence of open disclosure to the resident and relatives was verified in all accident/incident forms reviewed and in progress notes of corresponding files reviewed. A medical/nursing summary form in each resident file also records when families are contacted – following incidents, GP visits and medication changes.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a complaints policy that complies with Right 10 of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available in the rest home entrance and in the hospital hallway. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. Nine residents and two relatives confirm they are aware of the complaints process and they would feel comfortable lodging a complaint or discussing concerns with the nurse manager if necessary.</p> <p>There is a complaints register that is up to date and includes relevant information regarding the complaint. Complaints are managed by the nurse manager and provided to the PSSC elder care manager for collation and review. Verbal complaints are included. A complaints folder is maintained. There have been no complaints lodged for Margaret Wilson complex for 2013. All documentation for previous year's complaints and feedback including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder.</p>

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

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

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

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

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

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

**Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

PSSC Margaret Wilson is part of the Presbyterian Support South Canterbury (PSSC) services. PSSC has three residential homes, provides community services and Family works programmes. PSSC has a very involved board, which includes representatives from the community – clinical and non-clinical. The documented mission statement, states Presbyterian Support South Canterbury are dedicated to “supporting people with quality care and Christian love”. The service is managed by a nurse manager (registered nurse) who has been in this position for just over one year. She previously worked as the hospital team leader and has been employed at Margaret Wilson for 20 years. The nurse manager has qualifications in leadership and management and attends professional development and education related to managing an aged care facility. There is a strategic plan 2012-2017, which is reviewed monthly at board meetings. The CEO is provider representative for the district health board (DHB) health of older people for the South Island. This group gives key strategic direction for older person services in the South Island. These key directives link to the service strategic plans  
Key objectives include the Eden approach.  
Margaret Wilson provides hospital, rest home and young persons’ disabled level care and support for up to 70 residents. On the day of audit, there were 39 rest home residents, 20 hospital residents and 8 residents in the disabled unit. The service has a variety of contracts with the DHB for hospital care, palliative care, chronic health conditions and physical disability both aged related and non-age related. There were no respite residents on the day of audit. The organisation wide business plan 2012-2014 has the key objectives of; (i) protect reputation, (ii) minimise costs, (iii) manage complaints, (iv) manage H&S, (v) strategies to reduce risk, (vi) risks as opportunities, (vii) staff commitment. There is a facility quality plan 2013-2014, and a quality planner. There are documented indicators and targets. Benchmarking occurs with five other facilities. The nurse manager is supported by an elder care manager who visits the facility at least once a month and the nurse manager also attends monthly aged care managers’ meetings.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has a strategic plan and quality improvement plan that are implemented. The quality system and internal audit programme is designed to monitor contractual and standards compliance and the quality of service delivery. There is a strategic plan for 2012 - 2017 and a current quality plan (2013 -2014). Quality goals include partnership, leadership, person centred, education and training, teamwork, total organisational involvement in quality, risk management, use of measure and information, quality improvement system, and effective communication strategies. The monthly and annual reviews of this programme reflect the service's commitment to continuous quality improvement. There is an internal audit schedule in place. There is evidence of the regular monitoring</p>

of a wide variety of aspects of the service via this internal audit schedule, the education planner and meeting planner. In addition, there is opportunity for each service under PSSC to conduct quality improvement initiatives. An example of a recent quality initiative at Margaret Wilson is the opening of a shop twice a week. This initiative was in response to residents request and is very popular with residents. Another initiative is a nurse led clinic, which is held every week day morning for rest home residents for blood pressure monitoring, discussion and information around medication and general nursing care. Further quality improvements include: a calendar for 2014 developed by and with residents and local polytechnic photography students; and polypharmacy review with local general practitioners and pharmacists. The Eden philosophy is implemented at Margaret Wilson and an Eden focus group meets monthly to monitor progress with meeting the principles.

Feedback and progress relating to quality and risk management systems is provided during staff meetings and monthly CQI/management meetings at head office. The quality assurance/staff meeting includes (but is not limited to) feedback pertaining to: internal audits; quality initiatives; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; education. Minutes are maintained and easily available to staff in the staff room (minutes sighted for 20 November 2013). Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates PSSC Margaret Wilson's commitment to on-going quality improvement. The service has made improvements in this area. Discussions with the nurse manager, hospital team leader, two registered nurses, and five caregivers confirm their involvement in the quality programme. The CQI/managers' meeting held monthly is where benchmarking, facility reports and policy review is received (minutes sighted for 26 November 2013).

Resident/relative meetings take place monthly – minutes sighted for November 2013. Discussion is held around activities, meals, outings, health and safety and Eden principles being implemented at Margaret Wilson.

Meeting minutes are written in corrective action format and are reviewed for progress and outstanding actions at the beginning of each meeting.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. The reviews of the policies and procedures are scheduled to be completed on an annual basis and is discussed at CQI meetings held at head office. A document control system is in place. Documents no longer relevant to the service are removed and archived. Policies and procedures that are updated are documented on a document control sheet that is held in the front of each policy manual. The nurse manager reports staff are made aware of policy updates via staff meetings, memos and copies of policy updates are posted in the staff room. The service has made improvements in this area.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety meetings are held three monthly to discuss hazard management, falls and incidents, and hazard identification.

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

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

The service collects information on resident incidents and accidents, and staff incidents/accidents. Incident/accident forms are completed and given to a registered nurse who completes the follow up. All incident/accident forms are seen by the nurse manager who completes any additional follow up and collates and analyses data to identify trends. Data is being benchmarked against three other PSSC aged care facilities and two other local aged care facilities.

Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through resident/relative meetings and surveys are followed up and actioned.

Infection control data is collated monthly and reported to staff. Staff interviewed are well informed about infection control. Data is being benchmarked against

other aged care facilities.

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

Restraint/enabler use is reviewed and reported at the monthly CQI/management meeting at head office and at the three monthly staff meetings. Results of internal audits, reports from incidents and accidents, infection rates, restraint use and health and safety issues are discussed with staff through the three monthly staff meetings. This meeting incorporates discussion around health and safety, resident issues, infection control, education and quality assurance. Staff are able to contribute to the staff meeting agenda and a communication book also records outcomes of audits, and infection rates. The outcomes of audits, infection rates and falls incidence are displayed on the staff room notice board.

A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually. Internal audits are completed and include the identification of any issues and corrective actions where required. Internal audits conducted for 2013 include health and safety, kitchen, laundry, cleaning, privacy, care plans and medication. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored. Resident/relative meetings occur monthly. Annual resident satisfaction surveys and family satisfaction surveys are completed –last conducted May 2013. The survey attracted an 70% return rate with 100% of hospital residents and 94% of rest home residents surveyed agreed with the statement that they were happy with the overall quality of the service. Positive comments were received in relation to meals, staff, activities and the homely environment. The Eden initiative is implemented with a further three principles now in place addressing loneliness, helplessness and boredom.

#### **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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Criterion 1.2.3.8 (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.

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

**Criterion 1.2.3.9 (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.

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

### **Standard 1.2.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Discussions with the nurse manager confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications. The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident by the individual witnessing the event, with immediate action noted by the registered nurse on duty and any follow up action required. The nurse manager signs off on all adverse events. Minutes of the staff meetings reflect a discussion of incidents/accidents and actions taken. A sample of incident/accident forms were selected for review from December 2013 and involved five residents – two rest home, two hospital and one YPD resident. Investigations are conducted by a registered nurse (RN). Both RN and nurse manager sign the forms when the investigation is completed. Accident and incident forms, and records in the medical/nursing summary provide evidence that families are kept informed - and confirmed on family interviews. Appropriate clinical assessment and follow up of the resident is conducted (and referral when necessary) with the exception of one resident post head laceration did not have the appropriate follow up (link #1.3.6.1). Short term care plans are not utilised for all incidents when required (link # 1.3.8)

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

### **Evidence:**

PSSC Margaret Wilson employs approximately 80 staff. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including registered nurses and general practitioners is kept. Current practising certificates were sighted for all registered health professionals.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (one registered nurse hospital team leader, one registered nurse for the rest home, one diversional therapist and three caregivers). Reference checks are completed before employment is offered and are evident in staff files reviewed. Police vetting is not routinely conducted. Signed employment contracts and job descriptions are held at the PSSC head office in Timaru.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Five caregivers interviewed were able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the nurse manager for staff who require additional training. Orientation programmes are specific to the service type (e.g., RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all six staff files audited). PSSC conducts orientation study days for new staff and topics include Valuing the Older Person, dementia and communication, restraint minimisation, manual handling, continence and code of consumer rights education.

Discussion with the nurse manager and staff confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed education plan for 2013 and a plan for 2014. The annual training programme exceeds eight hours annually. Additionally, all caregivers are required to undertake aged care education within three months of commencement of employment. Five caregivers interviewed have either completed the National Certificate in care of the elderly or are working towards completion. The registered nurses are able to attend external training including conferences, seminars and sessions provided by South Canterbury District Health Board (SCDHB).

In 2013 there were a variety of in-service training sessions provided for staff including but not limited to: heart disease (18 staff attended); infection control (40); nutrition (24); fire training; syringe driver training for RN's; (15); palliative care (7 RN's); manual handling (24). Fire drill last conducted in November 2013. Medication education around insulin giving, and polypharmacy has been provided. Medication competencies have not been maintained for all caregivers with medication administration responsibilities and it is noted that registered nurses have not completed medication competencies (link #1.3.12). First Aid training for staff conducted in October 2013. Education records are maintained and are up to date. The nurse manager maintains comprehensive staff records to identify training needs and attendance. This is an improvement from the previous audit.

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

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

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

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

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

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

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

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

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

**Criterion 1.2.7.5 (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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. The nurse manager works full-time Monday-Friday and there is at least one registered nurse on duty at all times in the hospital wing. There is a registered nurse on duty in the rest home during the weekdays. Caregivers are rostered on to provide adequate cover in the all three care service areas and work a mixture of short and long shifts. There is a minimum of one registered nurse and three caregivers on overnight. An occupational therapist attends the facility for four hours every three weeks and as required. A physiotherapist is contracted to provide services and assesses all new residents. A diversional/activity therapist works Monday to Sunday. Designated staff attend to resident's laundry and cleaning of the facility. The kitchen staff are provided by an external contractor. Caregiver staffing fully complement the service meeting ARC contractual requirements. The nurse manager reports staff numbers are adjusted based on resident acuity and the occupancy rate.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

Wound care assessments and treatment plans were reviewed. Wound care management is maintained within the individual file. The service currently is managing thirteen wounds (six in rest home and seven in hospital). There are no wounds related to pressure. A lifestyle care plan is used for activities with activities assessments, client profile, activities records and six monthly evaluations completed by the diversional therapist.

Staff (two registered nurses and one nurse manager) were familiar with the timeframes and files reviewed were kept up to date.

Nurse manager and registered nurses (one hospital, one rest home) stated that family are, where appropriate, involved from time of admission and continue to be involved when there is a review of the integrated care plan. Communication with family is documented in the progress notes and highlighted with a stamp; this was confirmed during resident/family interview.

D 4.1 (e) The significant people and next of kin are documented in the admission forms of resident files reviewed.

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

D16.5e; Medical assessments were documented in six of six long-term files reviewed within 48 hours of admission. Three monthly medical reviews were documented in all six files by a general practitioner. It was noted in five of six resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly and one hospital file identified that the resident was unstable and was to have monthly reviews. On interview the GP advised that residents are seen three monthly or more frequently if required. More frequent medical assessment/ review noted occurring in residents with acute conditions.(link # 1.3.8)

Assessment tools available for completion on admission include a) pressure area risk assessment, b) pain assessment and pain charts, c) challenging behaviours and monitoring forms, d) continence assessment, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly. Annual clinical reviews are conducted for all residents and include input from the GP, RN, physiotherapist, occupational therapist, family and other allied health professionals.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Six files reviewed evidence this is occurring. The physiotherapist visits and assesses all new residents and attends as required. The GP interviewed stated that the service is prompt at informing of changes in the residents conditions and that instructions are carried out.

Tracer Methodology:

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

Tracer Methodology:

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

Hospital - Resident recently admitted to Margaret Wilson 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.

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

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

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

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

**Criterion 1.3.3.4 (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.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Previous certification audit identified that integrated care plans did not capture all interventions required to meet identified needs and issues. There is a daily care interventions form and an integrated care plan, which are developed following the assessment process.

The daily care interventions plan contains the following headings: personal care, nutrition, mobility transfers and physio, restraint, cognitive abilities, pain, medication, elimination, sleep and rest, social activities. The need and risk had been identified through the assessment processes; however, specific goals or objectives had not always been developed and included in the integrated care plan.

Of the six files reviewed, three of those residents were interviewed and all three reported their needs were being appropriately met. The daily care interventions form includes: personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture, medication, controlling pain, sleeping patterns/rest, intimacy/sexuality, communication, memory loss/confusion, challenging behaviour. Interview with two registered nurses and one nurse manager verified involvement of families in the care planning process.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The integrated care plan template captures identified problem/need, resident goals, interventions, evaluations, date and signature. The files reviewed identified the need and risk had been identified through the assessment processes; however, specific goals or objectives had not always been developed and included in the integrated care plan. This remains an improvement required from the previous audit.

**Finding:**

Three of three rest home, two of two hospital and one of one young disabled hospital files identified goals/objectives and interventions are not documented in the daily care plan and integrated care plan for all identified issues and needs e.g. (i) Resident in the hospital with XXXX (January 2014) did not have any specific intervention for this acute episode, there were gaps in resident monthly monitoring of weight, sexuality and intimacy was not covered in care plan. (ii) One hospital resident receiving insulin medication had no documented needs in regards to management of his diabetes. (iii). Rest home resident with a head laceration following a fall was receiving no neurological monitoring post injury. (link 1.2.4.3). One hospital and one rest home file identified there were gaps in weight management.

**Corrective Action:**

Ensure that the daily care plan and integrated care plans capture all identified needs and issues and that goals/objectives, and interventions are documented.

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Six resident files (three rest home, two hospital and one younger disabled hospital) were reviewed and included;

Hospital- (i) resident with palliative care needs, (ii) Resident who falls frequently.

Rest home- (i) Resident with recent surgery, (ii) Frequent faller, (iii) Resident with a wound

Younger disabled- (i) Physical disability.

The daily care interventions form includes: personal hygiene and dressing, elimination, eating and drinking, mobilising, expressing spirituality and culture,

medication, controlling pain, sleeping patterns/rest, intimacy/sexuality, communication, memory loss/confusion, challenging behaviour. (link # 1.3.5.2)  
 The integrated care plan identifies specific care needs for each resident and includes problem/need, objectives, interventions, evaluation for identified issues, however care plans did not include adequate information to direct staff in the delivery of some aspects of care (link 1.3.5.2).  
 There were short term care plans in six of six files reviewed (link # 1.3.8)  
 D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.  
 Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.  
 Continence management in-services and wound management in-service have been provided.  
 Wound assessment and wound management plans are in place for 13 residents (six rest home and seven hospital). No wounds were identified as pressure related.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are three Diversional Therapist (DT) and one activity coordinator employed by the service, who work Monday to Sunday for a total of 77 hours per week. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day are displayed on a notice board.

A client profile and activities assessment is completed on admission, which forms the basis for the diversional therapy plan. The plan includes goals and ambitions as well as a plan of meaningful activities. The resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that includes activities documentation. The programme is evaluated and can be individually tailored according to resident's needs. The DT advised that residents are able to participate in community activities as well as activities in the service itself.

Activities include (but not limited to): outings, exercises, walking bus, gardening, happiness club, housie, happy hour, seasonal celebrations, making pickles and jams, crafts, painting, knitting and sewing, bowls, individual one to one time, weekly church services, newspaper reading by a volunteer. One on one activities are provided for residents less mobile and able. There is a specific programme for the young disabled residents.

Resident meetings are held three monthly with feedback relating to activities provided at the meeting.

All nine residents (four hospital, two younger persons and three rest home) and two family members (hospital) interviewed discussed enjoyment in the programme and the variety offered to all residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Care plans are evaluated at least three monthly for hospital and disability residents and six monthly for rest home residents and if there is a change in the health status of the resident.

The GP reviews resident's medical condition and medication charts at least every three months.

Short-term care plans are not utilised for all acute issues.

D16.4a Care plans are evaluated at least three monthly for hospital and disability residents and six monthly for rest home residents.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Short-term care plans are available; however they are not always used to document short-term acute issues as identified in two of three rest home files.
<b>Finding:</b> Short-term care plans are available; however they are not always used to document short-term acute issues. E.g. (i) There was no STCP written for a rest home resident suffering with shortness of breath and swollen legs and (ii) No STCP written for rest home resident with acute XXXXX and on another occasion same resident suffered an acute XXXXX.
<b>Corrective Action:</b> Ensure that STCP are documented for all acute issues when progress is different to what is expected.
<b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The service uses four weekly blister pre-packed medication packs for all residents at Margaret Wilson complex. Pharmacy delivers medications every 28 days for regular medications and once a week for controlled drugs. A registered nurse advised that medication packs are checked and reconciled against medication charts upon arrival to the facility and signed off when reconciliation is complete. One caregiver and one registered nurse were observed to administer medication safely- checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation after administration.  Medication charts have photo ID's and all allergies are clearly recorded on the front of the medication chart. A list of specimen signatures is kept in the front of each medication folder. Twelve resident medication charts were reviewed. It was noted that three of 12 medication signing sheets reflect a failure to include a signature after medication administration. All medications are current on all trolleys, however two eye drop containers on the hospital medication trolley reflect no date and time of opening on the container. Improvements are required in these areas. Medications are stored in a locked treatment room in each the rest home and hospital units. Controlled drugs (CD) are stored in a locked safe in each medication room. Controlled drugs are checked by the pharmacist and registered nurse on arrival. Controlled drug book shows evidence of two signatures for all controlled drug administration, however, not all

controlled drugs have evidence of a weekly balance check. Two medication signing sheets for control drug administration only shows evidence of one staff signature. Improvement is required in this area.

Registered nurses administer medications in the hospital and caregivers administer medications in the rest home and disability unit. Medication education and competency is provided for caregiving staff that have responsibilities in administering medications. It is noted that annual competency has not been maintained and that registered nursing staff have not completed medication competency. Improvements are required in this area. The staff procedure folder reviewed evidence of a policy on annual staff medication competencies. The medicine fridge in the rest home and hospital is monitored daily and temperatures are within the recommended guidelines.

Unused medications and expired medications are returned to the pharmacy. Medication charts for the 12 residents reviewed evidence that the GP has signed for all the individual medications. This is an improvement from the previous audit. There were no respite residents on the day of the audit.

As required (PRN) medications are correctly charted by the GP and the prn signing sheet includes a time and signature. All medication charts reviewed show evidence that the GP reviewed medications three monthly. There is currently one resident self-medicating in the rest home and a competency assessment has been completed by the registered nurse. Integrated care plan reflects that the resident self-medicates. The resident maintains the medication in a locked drawer in her room. The registered nurse review stock weekly and record in a notebook that is kept in the locked drawer.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service uses four weekly blister pre-packed medication packs for all residents at Margaret Wilson complex. Pharmacy delivers medications every 28 days for regular medications and once a week for controlled drugs. A registered nurse advised that medication packs are checked and reconciled against medication charts upon arrival to the facility and signed off when reconciliation is complete. One caregiver and one registered nurse were observed to administer medication safely- checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation after administration.

Medication charts have photo ID's and all allergies are clearly recorded on the front of the medication chart. A list of specimen signatures is kept in the front of each medication folder. Twelve resident medication charts were reviewed. Medications are stored in a locked treatment room in each the rest home and hospital units. Controlled drugs (CD) are stored in a locked safe in each medication room. Controlled drugs are checked by the pharmacist and registered nurse on arrival. Controlled drug book shows evidence of two signatures for all controlled drug administration.

**Finding:**

(i)It was noted that three of 12 medication signing sheets reflect a failure to include a signature after medication administration; (ii) Two eye drop containers on the hospital medication trolley reflect no date and time of opening on the container; (iii) weekly controlled drug stock checks have not been conducted; (iv)

controlled drug administration records do not evidence two staff signatures.

**Corrective Action:**

(i) Ensure that all medications administered are signed for; (ii) ensure that eye drop medications are dated at time of opening; (iii) conduct weekly controlled drug checks as per guidelines; (iv) ensure that controlled drug administration sheets evidence two staff signatures.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Registered nurses administer medications in the hospital and caregivers administer medications in the rest home and disability unit. Medication education and competency is provided for caregiving staff that have responsibilities in administering medications. The staff procedure folder reviewed evidence of a policy on annual staff medication competencies.

**Finding:**

It is noted that annual competency for caregivers has not been maintained and that registered nursing staff have not completed medication competency.

**Corrective Action:**

Ensure that all staff with medication administration responsibilities are assessed as competent to do so.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

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

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

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

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

**Standard 1.3.13: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  PSSC contract the provision of food services. The meals are prepared and cooked in the PSSC The Croft facility kitchen. The Food Service Manager, located at 'The Croft' has been in the role for over twenty years and is a qualified chef, and has NZQA implementing food safety qualifications. Alliance food service employs the staff at Margaret Wilson and includes cooks, and kitchen hands. All staff have Food Safety Certificates (NZQA US.167). The Alliance food service has an accredited Food Safety Programme (HACCP), which expires on 20-May-2014. The four weekly winter and summer menu is designed by the Food Service Manager and reviewed by a registered dietician, menu review conducted April 2013. The kitchen in Margaret Wilson is well appointed with two large fridges and a large freezer, and a store room/pantry. The kitchen has a whiteboard,

which record the needs and requirements of residents - pureed, reduction, low-fat, vegetarian, diabetic, and residents receiving supplements. The food service is notified of dietary requirements via a dietary requirements form, which is completed by the registered nurse. It includes likes and dislikes, modified diets and preferences.

Food is served from bain marie's in the rest home dining room and from a kitchenette in the hospital and YPD wings. The facility has recently introduced self-service breakfast for able rest home residents, which has been well received. Those residents who do not wish to self-serve or who are unable to, are served by the care staff.

A daily consolidated sheet is where staff record hot food temperatures prior to serving, and fridge and freezer temperatures. These were sighted. Food stored in the fridge and freezer is covered and labelled with a day of the week sticker. Advised that left over food is stored for 48 hours then discarded. The kitchen has a pantry with extra food stores - enough for three days if required in an emergency.

A registered dietitian conducts nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues. This was evident in six files reviewed. Dietary information is documented in the daily care interventions, and in the integrated care plan if there is an identified nutritional issue.

Advised that resident weights are monitored monthly or more frequently if required, however, it was noted on two of six resident files reviewed that there are gaps in the recording documents (link #1.3.6.1).

The daily menu is posted on the hall way notice board in the rest home and hospital area.

Resident satisfaction survey, which includes food and meal service, was conducted in May 2013. Food and meals are agenda items at the three monthly resident meetings. The service provides feedback forms in each PSSC facility specific for food service - "food for thought" - which provides residents and families further opportunities for feedback on meal service

**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.

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service has a current building warrant of fitness, which expires 1 June 2014.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are designated areas for the storage of cleaning and laundry chemicals. Some chemicals used are not clearly labelled and are not stored safely.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service laundry facility and cleaning rooms are in designated areas and are clearly named. Chemicals are stored in a locked room in the laundry. MSDS are available in folders in the laundry. Chemicals were observed to be poorly labelled and in an unlocked sluice room in rest home area. Chemicals seen in kitchenette areas were labelled with hand written labels and not the manufacturer's label. This remains unmet from previous audit.

**Finding:**

Not all bottles containing chemicals were clearly labelled. The sluice room is unlocked and two bottles with cleaning chemicals were on the bench.

**Corrective Action:**

Ensure chemicals are clearly labelled and stored correctly.

**Timeframe (days):** 30 (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

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## 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Restraint minimisation is overseen by a restraint coordinator (nurse manager). There are currently no residents identified as requiring restraint. There are 14 residents with enablers – 10 hospital residents with bedrails and four YPD residents with bedrails (and one with a lap belt). Policy states that the use of enablers is voluntary and is requested by the resident. Restraint/enabler training is included in the in-service training plan for 2014 – last conducted in 2012. The staff orientation study day held for all new and existing staff contains a session on restraint minimisation. Staff complete a questionnaire on restraint minimisation and safe practice – last completed in 2013.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in PSSC Margaret Wilson's infection control policy. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-coordinator (registered nurse team leader and PSSC infection control nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service.

The service utilises benchmarking within PSSC facilities and programmes on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility

Infection surveillance is an integral part of the infection control programme and is described in the infection control policy.

Monthly infection data is collected for all infections. All infections are entered on to an infection register. This data is monitored and evaluated. Outcomes and actions are discussed at the three monthly staff meetings and at monthly CQI/management meetings. Emergent issues are discussed at handover, recorded in the communication book and information and data is displayed on the staff notice board.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

**Criterion 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.

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