# Presbyterian Support Southland - Walmsley House

## Current Status: 26 February 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

Walmsley House rest home is part of the Presbyterian Support Southland (PSS) service. The service provides rest home level care services for up to 31 residents. On the days of the audit there were 26 rest home residents. The service has an organisational structure that supports the continuity of management and quality of care and support.

The nurse manager at Walmsley has been in the role for three years and is supported by the PSS director of older person’s services, a quality manager and the chief executive officer (CEO). The service has addressed seven of eight shortfalls from the previous certification audit around: development of a complaints register, re-establishing monthly minutes of resident meetings, implementing a programme of annual staff appraisal, ensuring staff attend compulsory training including and infection control training, and provision of food safety training for the weekend cook.

Further improvements continue to be required around documenting medication administration competencies. This surveillance audit identified improvements are required around completing all internal audits and developing corrective actions for all identified issues.

## Audit Summary as at 26 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 26 February 2014

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

### Organisational Management as at 26 February 2014

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

### Continuum of Service Delivery as at 26 February 2014

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

### Safe and Appropriate Environment as at 26 February 2014

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

### Restraint Minimisation and Safe Practice as at 26 February 2014

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

### Infection Prevention and Control as at 26 February 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.0) for peer review

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Presbyterian Support Southland |
| **Certificate name:** | Presbyterian Support Southland - Walmsley House |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Walmsley House | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 26 February 2014 | **End date:** | 27 February 2014 |

|  |
| --- |
| **Proposed changes to current services (if any):** |
|  |

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 26 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 5 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 12 | Total audit hours off site | 6 | Total audit hours | 18 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 9 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 25 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | 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 Thursday, 20 March 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Walmsley House rest home is part of the Presbyterian Support Southland (PSS) service. The service is able to provide rest home level care services for up to 31 residents. On the days of the audit there were 26 rest home residents. The service has an organisational structure that supports the continuity of management and quality of care and support. The nurse manager at Walmsley has been in the role for three years and is supported by the PSS director of older person’s services, a quality manager and the chief executive officer (CEO).  The service has addressed seven of eight shortfalls from the previous certification audit around: development of a complaints register, re-establishing monthly minutes of resident meetings, implementing a programme of annual staff appraisal, ensuring staff attend compulsory training including and infection control training, and provision of food safety training for the weekend cook. Further improvements continue to be required around documenting medication administration competencies. This surveillance audit identified improvements are required around completing all internal audits and developing corrective actions for all identified issues. |

|  |
| --- |
| **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 shortfalls have been addressed and monitored by the service relating to maintaining a complaints register. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| PSS Walmsley House 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 meetings. The service is active in analysing data with evidence of benchmarking outcomes with other similar aged care facilities. Improvements are required relating to ensure all internal audits are completed and corrective actions are identified and implemented following audits and meetings. Resident meetings are held and minutes are recorded, the service has made improvements in this area.  Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The service has addressed and monitored previous shortfall related to completion of staff appraisals and ensuring training requirements are completed. 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** |
| PSS Walmsley House has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning, care plan evaluations and that the interventions noted in the care plans are consistent with meeting residents' needs.  A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is an appropriate medicine management system in place. Improvement continues to be required relating to documentation of medication administration competencies for care staff. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility is purpose built, all building and plant have been built to comply with legislation. The service displays a current building warrant of fitness. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. There are no residents currently on the restraint register as using a restraint or an enabler. Policy states that the use of enablers is voluntary, requested by the resident. Restraint/enabler minimisation and challenging behaviour education has been provided. |

|  |
| --- |
| **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; improvements have been made in this area. 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** |
| **Standards** | 0 | 16 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 3 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Internal audits schedule for 2013 incomplete. Audits relating to hand washing, food service and one laundry audit not conducted. | Ensure all internal audits are completed as per schedule. | 90 |
| HDS(C)S.2008 | Criterion 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. | PA Low | Medication audit conducted in October 2013, but no corrective actions were developed following this quality activity. Non-compliance in some areas had been identified. Resident meetings take place on a monthly basis, however, no record of corrective actions or quality improvements made following these meetings are documented. | Document and implement corrective actions identified through all quality activities e.g. audits and residents meetings. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Medication competency documentation not evidenced, as PSS documentation for administration competency is not utilised. | Utilise PSS medication documentation to evidence that all staff who administer medications are competent to do so. | 60 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

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

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; 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.  Six 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 four care workers, six residents and two relatives.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is provided to residents on entry. D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. D16.4b The two 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 in five of five files reviewed. Progress notes 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.

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau.  Six 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. There is a complaints register that is up to date and includes relevant information regarding the complaint. Verbal complaints are included. A complaints folder is maintained. There is one complaint lodged to date in 2014 and eight resident related complaints lodged in 2013. All documentation relating to complaints and feedback including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder. The service has made improvements in this area. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Walmsley House is part of the Presbyterian Support Southland services (PSS). PSS has four residential aged care homes under the services for older people, and also provides community services and Family works programmes. PSS has a very involved board which includes representatives from the community. The documented mission statement, states Presbyterian Support South Southland will “provide an environment where the right of older people to respect, privacy and dignity are valued. An environment where they can enjoy security, acceptance, and companionship”. The values of the service include respect, compassion, family, community and accountability. The service is managed by an experienced nurse manager (registered nurse) who has been in this position for three years. There is a strategic plan 2010-2013 which has been reviewed with a new strategic plan for 2014 ready to be presented. The board meets monthly. The nurse manager reports to the director of older persons services who in turn reports to the chief executive officer of PSS. Key strategic objective include providing a quality service, raising the profile of PSS, people, respecting the Treaty of Waitangi and ensuring organisational robustness. Walmsley house provides rest home level care and support for up to 31 residents; on the days of audit there were 26 permanent residents and no respite residents... There is a facility quality plan for 2014, and a quality planner. There are documented indicators and targets. Benchmarking occurs with other similar type facilities. The nurse manager is supported by the director of service for older persons and an organisational quality manager.  The nurse manager attends more than eight hours annually of professional development relating to the management of an aged care environment. She has attended the two day annual aged care conference, attends monthly management meetings and attends professional development in services at Walmsley house. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a strategic plan for 2014 and quality improvement plan 2014 that are implemented. The quality system and internal audit programme is designed to monitor contractual and standards compliance and the quality of service delivery. Quality goals include providing a high level of service, education, medication management, improve quality documentation, promote resident satisfaction and promote staff satisfaction. The vision for Walmsley House is to provide an atmosphere where residents can enjoy security, companionship, dignity, acceptance and privacy. 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 of a wide variety of aspects of the service via the internal audit schedule, the education planner and meeting planner. However, it is noted that not all internal audits were completed as per the schedule in 2013. Improvements are required in this area. There is opportunity for each service under PSS to conduct quality improvement initiatives. Quality initiatives planned for 2014 include introducing a new medication chart, roll out of interRAI assessment tool, and further development of the quality manager’s role, and polypharmacy review for all residents.  Feedback and progress relating to quality and risk management systems is provided during staff meetings and monthly quality meetings. Monthly managers meetings are also held at PSS head office. The quality meeting and staff meeting agenda 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 January 2014 quality meeting and November 2013 staff meeting). Minutes include actions to achieve compliance where relevant. Discussions with one registered nurse, and four care workers confirm their involvement in the quality programme. The managers meeting held monthly is where benchmarking, facility reports and policy review is received.   Resident/relative meetings take place monthly – minutes sighted for January 2014. Discussion is held around activities, meals, outings, health and safety and laundry. The service has made improvements in this area.  D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy 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 management meetings held at head office.  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 as part of the monthly quality meetings 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.  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 and copies of policy updates are posted in the staff room. Staff sign when they have read new or revised policies.  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 other PSS aged care facilities and with QPS benchmarking service.  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. One registered nurse, one care supervisor and two care workers 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 schedule is in place for 2014. The completed audits for 2013 included infection control, personal hygiene, resident file audit, medication audit, restraint use, cleaning, laundry, health and safety, and care plans. Audits scheduled for 2013 but not completed included hand washing, food service, and one further laundry audit. Improvements are required whereby all audits are completed as per the schedule. Corrective actions are documented following identification of shortfalls in care and service following audits and meetings - with the exception of the medication audit and resident meeting minutes. Improvements are required in this area. 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 December 2013. The survey attracted less than a 50% return rate however, with 92% agreed with the statement that they were satisfied with the overall quality of the service. Survey questions related to care and service from staff (90% satisfaction), activities programme (78%), social environment (82%), accommodation and living areas (96%), comfort and surroundings (91%), medical care (86%), food (86%), cleaning and laundry (85%) and maintaining community contact (92%). |

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually. Internal audits schedule is in place for 2014. The completed audits for 2013 included infection control, personal hygiene, resident file audit, medication audit, restraint use, cleaning, laundry, health and safety, and care plans. Audits scheduled for 2013 but not completed, included hand washing, food service, and one further laundry audit. |
| **Finding:** |
| Internal audits schedule for 2013 incomplete. Audits relating to hand washing, food service and one laundry audit not conducted. |
| **Corrective Action:** |
| Ensure all internal audits are completed as per schedule. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Corrective actions are documented following identification of shortfalls in care and service following internal audits, quality meetings, staff meetings, complaints and incidents and accidents - with the exception of the medication audit and resident meeting minutes. |
| **Finding:** |
| Medication audit conducted in October 2013, but no corrective actions were developed following this quality activity. Non-compliance in some areas had been identified. Resident meetings take place on a monthly basis, however, no record of corrective actions or quality improvements made following these meetings are documented. |
| **Corrective Action:** |
| Document and implement corrective actions identified through all quality activities e.g. audits and residents meetings. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Discussions with the nurse manager and registered nurse confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications. D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents. 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 quality meetings and staff meetings reflect a discussion of incidents/accidents and actions taken. Nine completed incident/accident forms were randomly selected for review from January 2014 and involved five residents. All forms evidenced completion, medical and nursing follow up and changes to care planning if required. Incidents included falls, skin tears, and challenging behaviours. Investigations are conducted by the registered nurse. Both RN and 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. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| PSS Walmsley House employs 25 permanent 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 - registered nurses, GP and dietitian.  There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Four staff files were reviewed (one nurse manager, one registered nurse, and two care workers). Reference checks are completed before employment is offered and are evident in staff files reviewed. Police vetting is not routinely conducted. Signed employment contracts are held at the PSS head office in Invercargill. Annual performance appraisals have been completed. The service has addressed and monitored this previous finding. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two newly employed care workers 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 four staff files audited). PSS conducts a compulsory study days which all staff much attend every two years. Topics include culture and values of PSS, elder abuse, quality improvement, restraint minimisation, completing incident forms, documentation and privacy, infection control, Treaty of Waitangi and caring for the older person. Head office staff maintain records for staff attendance at the compulsory study day which staff must attend every two years. The service has made improvements in this area.   Discussion with the nurse manager, one registered nurse, two of four care workers (two recently employed) 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 in place for 2014. The annual training programme exceeds eight hours annually. Additionally, all care workers are required to undertake aged care education within three months of commencement of employment. Four care workers interviewed have all completed the National Certificate in care of the elderly. The registered nurses are able to attend external training including conferences, seminars and sessions provided by Southland District Health Board (SDHB).   Education provided in 2013 included manual handling, wound care, safe food handling, diabetes, care of a PICC line, use of emergency equipment, hand washing, emergency care, code of rights, medication training, advanced care planning, dementia and behaviours. First Aid training for staff has been provided. Education in 2012 included but not limited to: chemical handling. Previous audit identified that the week end cook was not trained in food safety unit standard 167. This has been addressed. Efforts are undertaken by the nurse manager to ensure in-service education is regularly attended by staff (evidenced in interviews with the nurse manager, registered nurse, and two of four care workers). Education records are maintained and are up to date. The nurse manager maintains comprehensive staff records to identify training needs and attendance. |

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.  Interviews with one registered nurse, four care workers, six residents and two family members identify that staffing is adequate to meet the needs of residents.  The nurse manager works full-time Monday-Friday and there is a registered nurse who provide an additional 32 hours registered nursing hours per week. A physiotherapist is contracted to provide services and assesses all new residents. The roster includes three care workers on the morning shift (one long shift and two short); two care workers on the afternoon shift (one long shift and one short); and two care workers on overnight. Two activities coordinators work 35 and 32 hours respectively from Monday to Saturday. Caregiving staff attend to resident’s laundry and there is designated cleaning staff. There is a full time cook Monday to Friday with meals provided in the week end from another PSS facility kitchen. Care worker 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 nurse manager and registered nurse are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long term care plans are to be completed within three weeks and align with the service delivery policy. Five files were reviewed with four of five long term care plans completed within the three week time frame (one recent admission) and appropriate assessments have been completed for all identified issues. The nurse manager has reassessed all long term residents using the interRAI assessment tool. Wound care assessment and treatment plans were reviewed and included one resident with an infected wound which is being treated and managed at the medical centre. Management of the wound is recorded in the resident’s long term care plan. Short term care plans have been developed for infections, skin tears, and short term care issues. A lifestyle care plan is used for activities with an activities assessments, client profile, activities records and six monthly evaluations completed by the activities staff.  Staff (one registered nurse and one nurse manager) were familiar with the timeframes and files reviewed were kept up to date. InterRAI assessment tool is in use, with the nurse manager having completed training. The registered nurse has yet to complete interRAI training.  D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours. A long term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluations are completed three to six monthly.  D16.5e; Medical assessments were documented in five of five long term files reviewed within 48 hours of admission. Three monthly medical reviews were documented in four of five files by a general practitioner (one recent admission). It was noted in four of five resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly. On interview the general practitioner (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. 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. Three monthly clinical and nursing reviews are conducted for all residents and include input from the GP, registered, physiotherapist, 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. GP’s from medical practices in Invercargill provide the service with visits to residents. On interview, the GP (who up to now has been the house doctor) advised that he visits the service fortnightly or more frequently if required. Medical, registered nurse and care worker progress notes are maintained. Progress notes are written at least daily or more frequently as required. Five files reviewed evidence this is occurring. The physiotherapist visits to assess residents as and when 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: Rest home resident. XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Five resident files were reviewed. Care plans are individualised and personalised to reflect needs, goals and outcomes in the long term care plan. Of the five files reviewed, three of those residents were interviewed and all three reported their needs were being appropriately met. The long term care plan headings include elimination, nutrition, hygiene and grooming, mobility, social, cultural and spiritual beliefs, cognitive/sensory, medication management, and skin care. Additions to the long term care plan were individual to each resident with further cares recorded for pain, behaviours, and wound cares. Care plans were current and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with one registered nurse and one nurse manager verified involvement of families in the care planning process. There were short term care plans in four of five files reviewed and include plans for infections, wounds, skin tears, pain management, changes in health status, return from acute care, behaviours and pain management. One resident with a wound demonstrate a link between additions to the long term care plan and wound management plans. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. The registered nurse and nurse manager interviewed described the referral process and related form should they require assistance from wound specialist or continence nurse. One resident with chronic mental health issues receives input from the community mental health team. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two activities staff. One works 35 hours per week and one works 32 hours per week. Activities are provided morning and afternoon from Monday through to Saturday. The programme is planned monthly and resident’s activities planned for the day are displayed on a notice board in the hallway.  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 include activities documentation. The programme is evaluated and can be individually tailored according to resident’s needs.  The activities staff (two) 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, walks, gardening, shopping, housie, happy hour, seasonal celebrations, bible study, bocce, bowls, individual one to one time, weekly church services, and newspaper reading by a volunteer. Volunteers also assist with the activities outings. Residents were observed participating in newspaper reading, two van outings, and ‘getting to know one another’ activity in the lounge. One on one activities are provided for residents less mobile and able. Resident meetings are held monthly with feedback relating to activities provided at the meeting. A resident committee made up of six residents also meets and provides feedback to the service. Residents attend activities in the community including Stroke club, Pacific Island community group, church services, art classes and family outings. All six residents and two family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Three of five care plans reviewed evidenced that the entire care plan evaluations are comprehensive, relate to each aspect of the long term care plan and record the degree of achievement of goals and interventions. One resident was a recent admission and a long term care plan has yet to be developed and one resident has been in the facility less than three months. Care plans reviewed are updated as changes are noted in care requirements. Short term care plans are well utilised for residents. Any changes to the long term care plan are dated and signed. Four of five care plans reviewed included handwritten updates to the plan as needs have changed for certain aspects of the plan.  Short term care plans were sighted for wounds, infections, pain management, and short term health issues.  D16.4a Care plans are evaluated three monthly or more frequently when clinically indicated D16.3c: All initial care plans were developed with 24 hours of admission and evaluated by the RN within three weeks of admission |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service uses individualised robotic medication packaging system. The medications are delivered monthly and checked in by the registered nurse. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications.  A care worker was observed administering medications to the residents, and followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in a locked treatment room. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.  Controlled drugs are stored in one locked safe inside the locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly and stock take is conducted six monthly. Medication fridge’s are monitored daily and recorded weekly. There are no residents on controlled drugs at time of audit, however, review of previous month evidenced correct documentation and records pertaining to controlled drug management.  Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies (or nil known allergies) are recorded on all 12 drug charts reviewed. An annual medication administration competency is completed for RN’s and care workers, however, this is not recorded on the PSS medication competency documentation. Improvements are required in this area. There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available. There are currently three residents who self-administer medications (inhalers). Documentation including assessment by the RN and GP is completed. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. As required medication orders (PRN) all record indications for use. D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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 Low |
| **Evidence:** |
| PSS nursing policy includes medication competency documentation – check list for completion and a record of medication administration observation. Advised that annual medication administration competency is completed for the registered nurse, nurse manager and care workers, however, this is not recorded on the PSS medication competency documentation. A list of those staff who have been observed as medication competent is maintained in the front of the medication folders. Staff complete a medication questionnaire every two years (as evidenced in staff files reviewed), however, these have not been marked. A care worker was observed administering medications to the residents, and followed correct administration procedures. |
| **Finding:** |
| Medication competency documentation not evidenced, as PSS documentation for administration competency is not utilised. |
| **Corrective Action:** |
| Utilise PSS medication documentation to evidence that all staff who administer medications are 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:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

|  |
| --- |
| **Attainment and Risk:** 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 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| PSS Walmsley House provide prepared and cooked meals for residents in the facility kitchen from Monday to Friday. The full time cook has been in the role for five years and has completed unit standards 167 and 168. Previous audit finding around weekend cook not having completed food safety qualifications has been addressed. The previous weekend cook was provided with training however, no longer works at the facility. The service has addressed this previous finding. The service does not currently have a weekend cook however, they are actively recruiting for a replacement. On the weekends, meals are cooked and delivered from another PSS facility kitchen. Food is transported in hot boxes and then served to residents. Hot food temperatures are checked and recorded prior to lunch and tea meal (recorded sighted). The four weekly winter and summer menu is designed and reviewed by a registered dietician. The kitchen in Walmsley House is well appointed with a combi-steam oven, electric hobs, a large fridge and a large freezer, a store room and pantry. The needs and requirements of residents are recorded and special diets are catered for. One resident is a vegan and the cook prepares dishes to her dietary requirements. Supplements are also provided for this resident.  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 directly from the kitchen servery to the dining room and staff were observed to be wearing head covering during two lunch time meal services. 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 large pantry with extra food stores - enough for three days if required in an emergency.  A registered dietitian is available to conduct nutritional assessments on residents and is able to develop nutritional plans for residents with identified weight issues. Dietary information is documented in long term care plan if there is an identified nutritional issue.  Resident weights are monitored monthly or more frequently if required.  The daily menu is posted on the dining room notice board. Resident satisfaction survey which includes food and meal service, was conducted in December 2013. Food and meals are agenda items at the monthly resident meetings. |

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

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

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

|  |
| --- |
| **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 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service displays a current building warrant of fitness which expires on 28 January 2015. |

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

All buildings, plant, and equipment comply with legislation.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint minimisation is overseen by a restraint coordinator who is the registered nurse. There are currently no residents identified as requiring restraint or enablers. Policy states that the use of enablers is voluntary and is requested by the resident. Restraint/enabler training is included in the compulsory study day which all staff must attend every two years. Staff complete a questionnaire on restraint minimisation and safe practice. Challenging behaviour management education provided in September 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.

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

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

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous certification finding relating to infection control coordinator training not been provided has been addressed and monitored. Refer #3.4. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous certification audit identified that a) the infection control coordinator had not attended infection control training (previous finding #3.2.3) and b) that staff records did not record who had and had not attended infection control training (previous finding #3.4.4).  The current registered nurse is the infection control coordinator at Walmsley House and has completed two on-line learning courses related to infection control and hand hygiene in February 2014. The IC coordinator has access to PSS support for infection control matters, the laboratory and infection control expert at the local hospital. The service has established a training data base which is managed from head office. All staff are required to attend a compulsory study day every two years. Topics provided include infection control training. Hand washing education was also provided at Walmsley House in April 2013. The service has addressed and monitored these previous findings. |

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

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

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

#### 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 PSS Walmsley House’s infection control policy. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC Co-Coordinator (registered 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 PSS 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 monthly staff meetings, at monthly quality meetings and PSS 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:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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