

# Presbyterian Support Services Otago Incorporated - Holmdene

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Current Status: 19 March 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

Holmdene home and hospital is part of Presbyterian Support Otago. The service provides rest home and hospital (medical and geriatric) level care for up to 35 residents. All the beds are assessed as dual-purpose beds. On the day of audit, there were 13 residents at rest home level and 21 at hospital, one of which is palliative care.

The service is managed by a suitably qualified manager. This audit identified three low risk findings around the documentation of audit follow-up, annual appraisals for staff and aspects of care planning documentation.

## Audit Summary as at 19 March 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
<span style="background-color: blue;"></span>	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
<span style="background-color: green;"></span>	No short falls	Standards applicable to this service fully attained
<span style="background-color: yellow;"></span>	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
<span style="background-color: yellow;"></span>	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
<span style="background-color: red;"></span>	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 19 March 2014**

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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## **Organisational Management as at 19 March 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.
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## **Continuum of Service Delivery as at 19 March 2014**

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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## **Safe and Appropriate Environment as at 19 March 2014**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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## **Restraint Minimisation and Safe Practice as at 19 March 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 19 March 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 Otago Incorporated	
<b>Certificate name:</b>	Presbyterian Support Services Otago Incorporated - Holmdene	
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited	
<b>Types of audit:</b>	Surveillance Audit	
<b>Premises audited:</b>	Holmdene Rest home	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	<b>Start date:</b> 19 March 2014	<b>End date:</b> 20 March 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>	34
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## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	8
<b>Other Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	12	Total audit hours off site	10	Total audit hours	22
Number of residents interviewed	5	Number of staff interviewed	11	Number of managers interviewed	4
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	4
Number of medication records reviewed	10	Total number of staff (headcount)	55	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	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 Tuesday, 29 April 2014

# Executive Summary of Audit

## General Overview

Holmdene home and hospital is part of Presbyterian Support Otago. The service provides rest home and hospital (medical and geriatric) level care for up to 35 residents. All the beds are assessed as dual-purpose beds. On the day of audit, there were 13 residents at rest home level and 21 at hospital, one of which is palliative care.

The service is managed by a suitably qualified manager. This audit identified three low risk findings around the documentation of audit follow-up, annual appraisals for staff and aspects of care planning documentation.

## Outcome 1.1: Consumer Rights

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

## Outcome 1.2: Organisational Management

There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO.

There is a documented current business plan and a quality plan, which includes clear goals for the coming year. Quarterly reports are documented against specific areas of the annual business and quality plan

Holmdene implements the organisation quality plan through a series of audits, data collection and meetings. There is a new meeting structure for this service, which is in its infancy. Six weekly 'all staff' meetings are held in which information is shared between the various staff groups. Health and safety meetings are documented two monthly and resident meetings four to six weekly. Registered nurse meeting discusses clinical aspects of care. Relevant information, changes and improvements are also shared between these three meetings. There is an implemented audit schedule.

There are improvements required around; follow up of audit outcomes, action plan following a survey and discussion of all quality outcomes at relevant meetings.

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

## Outcome 1.3: Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Support plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing support plans. Support plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated three monthly or more frequently when clinically indicated. Risk assessment

tools and monitoring forms are available to assess effectively the level of risk and support required for residents. This audit identified improvements required around care plan documentation, use of STCP and wound care plans. The medication management system includes medication policy and procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents' general practitioner at least three monthly. The service has food policies/procedures for food services and menu planning appropriate for this type of service. Dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs.

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

The service displays a current building warrant of fitness.

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

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has no residents requiring restraint or enablers.

## **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 on the surveillance-monitoring summary.

## **Summary of Attainment**

	<b>CI</b>	<b>FA</b>	<b>PA Negligible</b>	<b>PA Low</b>	<b>PA Moderate</b>	<b>PA High</b>	<b>PA Critical</b>
<b>Standards</b>	0	13	0	3	0	0	0
<b>Criteria</b>	0	36	0	3	0	0	0

## 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 1.2.3.1	The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Low	There is an implemented audit schedule however, follow up of audits is not always documented as occurring, examples include the December 2013 medication audit and hot water temperature monitoring audits. (One RN and four caregivers all report that problems identified by audits are always followed up and actions). A resident survey was documented for April 2013. This survey has no follow up documented. Meetings do not always document discussion of quality statistics.	Ensure that audit and survey outcomes are documented as followed up and signed off when completed and meetings document discussion of quality outcomes.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing	PA Low	Six staff files reviewed. Of the three staff who	Continue with the process of ensuring all staff have a	60

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
		education for service providers to provide safe and effective services to consumers.		have been employed for over a year there is no annual appraisal documented. The manager has a process to ensure all appraisals are up to date this year.	documented annual appraisal.	
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	(i) The resident with a recent fall and sutures to her head does not have a short term care plan or wound care plan in place. (ii) The resident with the need for pain control has xxxxx patches, but the review of their effectiveness is not well documented. (iii) One resident with a chronic wound has this documented in the LTCP but no specific instructions for caregivers regarding its care. (iv) Three residents using xxxxx patches have no documented rotation of patch site. (v) The care plans for residents with wrist alarms do not include direction of staff with regard to diverting residents who may wander.	Ensure the effectiveness of analgesia is documented. (ii) Ensure STCPs and wound care plans are in place for residents with wounds. (iii) Ensure care plans document all care and support needed.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

## 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:

Holmdene has a documented open disclosure policy in place which includes the resident and family rights (where appropriate) to full and open disclosure. Two relatives and five residents (two rest home and three hospital) all stated that the service communicates very well and were given information on admission to services.

Five resident files reviewed all document that family are kept informed and this is documented through progress notes, family contact sheets and MDT meetings.

Five files reviewed (two rest home and three hospital) all have signed admission agreements.

There are policies and procedures available for access to interpreter services and residents (and their family/whānau).

Four incident forms reviewed (three falls and one related to dental care) all document that families have been informed. Progress notes also include family communication.

D12.1: Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet.

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet.

D16.4b: Residents and relatives interviewed confirmed they are kept fully informed.

D11.3: The admission booklet is available in large print and can be read to residents if required.

#### 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:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided.
There is one documented complaint from 2014. All complaints are logged onto the computer, which documents the complaints register. The computerised complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved.
Details of the management of the complaint are recorded including follow up and response. The one complaint reviewed documents that the family are happy with the outcome. Complaints are discussed at the staff/ quality and risk management meetings, at organisational level.
D13.3h: A complaints procedure is provided to residents within the information pack at entry.

**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> (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.

<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.)

## 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:**

Holmdene home and hospital is part of Presbyterian Support Otago (PSO). The service provides rest home and hospital (medical and geriatric) level care for up to 35 residents; all the beds are assessed as dual-purpose beds.

On the day of audit, there were 13 residents at rest home level and 21 at hospital, one of which is palliative care.

There is a documented organisation wide quality plan, philosophy and vision statement. There is also a business plan that includes strategic direction and the service philosophy of "Valuing the lives of Older People". The implementation of this philosophy was documented though a review of five care plans and interviews with four caregivers.

There is a PSO governance structure, which includes a Clinical Governance advisory group made up of external and internal clinical representatives. Managers from all seven facilities report monthly to the Director of Services for the older person, and there is support for the facility from the organisational quality adviser, the operations support manager and the clinical nurse adviser, all three were on site at different times during the audit to support the manager.

The Nurse Manager (RGON) has been in this position for six months, she is a registered nurse (RN) with wide experience in both community and hospital care.

There is a comprehensive health & safety programme in place.

## **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.

<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 1.2.3: 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> PA Low
<b>Evidence:</b>
There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO.
There is a documented current business plan and a quality plan, which includes clear goals for the coming year. Quarterly reports are documented against specific areas of the annual business and quality plan.
There is an organisational quality advisor who oversees the quality management systems and to provide further accountability for corrective actions and quality improvement initiatives. The organisation has a range of continuous quality improvement work streams in place, which include: infection control, documentation, continence, restraint, dementia, wound care, moving and handling, falls, medications, palliative care, policies and procedures, benchmarking, financial, competencies, workforce development, and Valuing lives. Each group is led by a designated manager/leader. The role of each group is to address the needs identified within each specialised work stream. Projects and issues are identified by the managers group (six weekly meeting) and allocated to the appropriate work stream for research, review and action planning.
Quality outcomes are collated monthly with three monthly benchmarking across the organisation.
Holmdene implements the organisation quality plan through a series of audits, data collection and meetings
The outcomes of the organisation wide continuous improvement groups are reported back to the six weekly staff/ quality meetings. There is a new meeting structure for this service and it is in its infancy. As a consequence, the agenda items of incident and accidents, infection control, complaints are not documented as discussed for November and January 2014 with improvements noted in subsequent meetings. Health and safety meetings are documented two monthly and resident meetings four to six weekly.
Staff have access to these meeting minutes in the staff room (confirmed by four caregivers at interview).

Registered nurse meeting agenda covers clinical issues, medication errors, education sessions and general business.

There is an implemented audit schedule; however follow up of audits is not always documented as occurring, examples include the December 2013 medication audit and hot water temperature monitoring audits. (One RN and four caregivers all report that problems identified by audits are always followed up and actions). The documented follow up of audits is identified as an area for improvement.

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.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use 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. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

D5.4: The service has comprehensive policies/ procedures to support service delivery.

D10.1: Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

There are procedures to guide staff in managing clinical and non-clinical emergencies.

D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.

A resident survey was documented for April 2013. This survey has no documented follow up and this is identified as an area for improvement.

### **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:** PA Low

**Evidence:**

The service is in the process of implementing a new meeting structure, which shows improvements in reporting in recent months. There is an audit schedule, which is implemented.

**Finding:**

There is an implemented audit schedule however, follow up of audits is not always documented as occurring, examples include the December 2013 medication audit and hot water temperature monitoring audits. (One RN and four caregivers all report that problems identified by audits are always followed up and actions). A resident survey was documented for April 2013. This survey has no follow up documented. Meetings do not always document discussion of quality statistics.

**Corrective Action:**

Ensure that audit and survey outcomes are documented as followed up and signed off when completed and meetings document discussion of quality outcomes.

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

**Criterion 1.2.3.3 (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> (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.

<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 1.2.3.5 (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> (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.

<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 1.2.3.7 (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> (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.

<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 1.2.3.9 (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> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. Each month the manager enters all incidents and accidents into a database. All incidents and accidents are then collated and an action plan developed as needed (sighted). Incidents and accidents are graphed and a trend analysis developed and reviewed through head office and results communicated to the service. Benchmarking is documented against all the PSO homes with a service specific three monthly review of all incidents and accidents. The service continues to manage this process well.</p> <p>There is a discussion of accidents/incidents at two monthly quality / staff meetings, two monthly health and safety meetings and six weekly management meetings including actions to minimise recurrence (link 1.2.3.1). The Presbyterian support Continuous Quality improvement groups also review trends and associated work / improvements for incidents and accidents if they relate to the specific work stream. Falls, medication errors and skin tears are reported and benchmarked through internal benchmarking programme. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>There is an open disclosure policy and two family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incidents for four residents were reviewed. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the respective unit manager.</p> <p>D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b>
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 the registered nurses, podiatrist, pharmacists and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.
Six staff files were reviewed (one new appointment- new RN graduate, one more senior RN, and four caregivers). Advised that reference checks are completed before employment is offered as evidenced in all six staff files reviewed.
The new graduate nurse and two newly employed caregivers all have a documented three-month review. The new graduate RN is currently considering enrolling on the new graduate programme with the DHB.

All six files have staff contract and relevant job descriptions.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four care giver interviewed were able to describe the orientation process. Orientation checklists evident in all six staff files reviewed.

Discussion with the unit nurse manager, one registered nurse, one enrolled nurse and four care givers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2014. The annual training programme exceeds eight hours annually. Care workers either have completed the national certificate in care of the elderly or are working towards completion. The facility manager and registered nurses attend external training including conferences, seminars and sessions provided by PSO and the local DHB. The facility manager attends the six weekly managers' meetings which includes education and training related to managing the facility. Two RNs are enrolled on the interRAI training programme. Annual appraisals are identified as an area needing improvement with three of the six staff files reviewed not documenting annual appraisals (three staff are new and these staff have a three monthly review documented). The unit manager has a documented process to ensure that appraisals are brought up to date.

#### **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:**

<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 1.2.7.4 (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> (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b>
The service has a very comprehensive education programme. Attendance at training is documented and evidences that there is good attendance. The service philosophy of Values and social valorisation is also included in the compulsory education programme. Training exceeds eight hours and competencies (including medication) are documented on staff files.
<b>Finding:</b>
Six staff files reviewed. Of the three staff who have been employed for over a year there is no annual appraisal documented. The manager has a process to ensure all appraisals are up to date this year.
<b>Corrective Action:</b>
Continue with the process of ensuring all staff have a documented annual appraisal.
<b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

### **Attainment and Risk:** FA

#### **Evidence:**

The staffing levels guide and Human Resources (HR) policies includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and hospital residents.

The roster includes: manager 40 hours per week and also a clinical nurse coordinator who works 20 hours per week. There is at least one RN on every shift.

The AM shift includes seven care givers (three long shifts and four short); the PM shift includes five caregivers (three long shifts and two short) and one caregiver at night.

The RNs are the designated first aiders for each shift.

There are cleaners employed in each unit who work every day. Other staff include physiotherapist, an OT, activities staff, kitchen staff and maintenance and gardening staff. Interviews with one registered nurse, one enrolled nurse, four caregivers, four residents and two family members identify that staffing is adequate to meet the needs of residents.

### **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 assessment of residents and the development of lifestyle support plans is undertaken by the service's registered nurses who also have the responsibility for maintaining and reviewing support plans. An initial assessment and the beginning of the development of the residents care plan is expected to occur during admission. The full support plan is developed within three weeks.

Five resident files were reviewed for this audit (three hospital and two rest home). All five resident files including care plans documented that care plans are developed in consultation with other relevant people including residents and where appropriate family/whanau. This is documented on the support plan consultation sheet. On-going family communication is also documented

The five files documented evidence of other allied health services input at the admission process i.e. GP, physiotherapy, dietitian, occupational therapist and podiatry.

Two family members (one rest home, one hospital) interviewed confirmed their involvement.

Care workers complete progress notes at the end of each shift, with registered nurse entries supporting as required. There is an appropriate hand-over briefing between shifts that staff were able to fully describe.

D16.2, 3, 4: The five files reviewed (three hospital and two rest home) identified that in all five files an assessment was completed within 24 hours and all five files identify that the long term support plan was completed within three weeks. There is documented evidence that the support plans are reviewed by a RN and amended when current health changes. All six support plans evidenced evaluations completed at least three monthly.

D16.5e: Six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) mobility assessment, b) pressure area assessment, c) falls risk assessment, d) nutritional needs assessment, e) continence assessment, and f) pain assessment.

A short term care plan is completed by the registered nurses for changes in health status eg chest infections, urinary infections, and wound care.

##### **Tracer Methodology:**

Rest home.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The resident files and care plans reviewed (two rest home and three hospital) are completed comprehensively and are personalised and individual to the resident. The philosophy of social roles valorisation (VLOP) is evidenced to be implemented into the documentation and provision of care and support. Four caregivers interviewed were all able to describe the service philosophy.

The care being provided is consistent with the needs of residents. This is evidenced by discussions with two rest home and three hospital residents and two family members (one rest home, one hospital), one registered nurse, and one enrolled nurse.

Five care plans reviewed for this service; Three hospital level residents Falls, pain control and palliative care needs are well documented.

As part of the care plan review two additional resident with XXXX patched were reviewed, both had the need for pain control documented and medication charts are completed appropriately, however for the three residents using XXXX patches there is no documented rotation of patch site.

The service has two residents with exit alarms as wrist bands. The documentation for these two resident documents that family have been consulted. Four caregivers consulted all were able to describe how they would divert these (wandering) residents should they leave the building. However, this is not well documented in the care 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 an assessment for 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 was provided in July 2013. Wound management in-service was provided in August 2012.

Wound assessment and wound management plans are in place for seven residents. Two wounds are pressure related, district nurse input is documented. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

During the tour of facility it was noted that all staff treated residents with respect and dignity, five residents (two rest home, three hospital) and two family members (one rest home, one hospital), were able to confirm this observation.

GP interviewed confirmed that staff are prompt at communicating changes in resident health status and complete interventions as requested.

### **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:** PA Low

##### **Evidence:**

Five care plans reviewed for this service; Three hospital level residents; - one resident with falls, one resident with the need for pain control and one new resident ( palliative care).

Falls, pain control and palliative care needs are well documented.

Two rest home resident files included a new resident with a chronic wound and a frail resident with a chest infection. As with the hospital care plans are well documented. As part of the care plan review two additional residents with XXXXX patches were reviewed, both had the need for pain control documented and medication charts are completed appropriately,

The service has two residents with exit alarms as wrist bands. The documentation for these two resident documents that family has been consulted. Four care givers consulted all were able to describe how they would divert these (wandering) residents should they leave the building. However this is not well documented in the care plans.

##### **Finding:**

(i) The resident with a recent fall and sutures to her head does not have a short term care plan or wound care plan in place. (ii) The resident with the need for pain control has XXXXX patches, but the review of their effectiveness is not well documented. (iii) One resident with a chronic wound has this documented in the LTCP but no specific instructions for caregivers regarding its care. (iv) Three residents using XXXXX patches have no documented rotation of patch site. (v) The care plans for residents with wrist alarms do not include direction of staff with regard to diverting residents who may wander.

##### **Corrective Action:**

Ensure the effectiveness of analgesia is documented. (ii) Ensure STCPs and wound care plans are in place for residents with wounds. (iii) Ensure care plans document all care and support needed.

**Timeframe (days):** 90 (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:**

D16.5d Resident files reviewed (six -two rest home and three hospital)) evidenced resident profiles, assessment and activity interests, including individual goals in relation to activities. A comprehensive resident social profile is completed on admission.

There are two activity coordinators across 35 hours a week. Both activities coordinators have been trained in the 'Valuing Lives' programme (social role valorisation).

Interviews with the activity therapist described the overall programme and link to Valuing Lives.

The activities coordinators attend the PSO Activity training days 2 -3 times a year run by the Occupational therapist.

The activities programme is varied and it includes activities such as; a) falls prevention exercises, b) bowls, c) cooking, d) newspaper reading, e) outings, f) entertainment, g) gardening, h) quizzes, i) flower arranging, j) crafts, k) library, l) services in the chapel, m) bible study group, n) happy hour and o) housie.

The two rest home and three hospital residents interviewed both praised the activities programme.

The activity programme is developed with the residents (and relatives) and this is reviewed two monthly by the activities team.

## **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:**

D16.3c: All initial support plans are evaluated by the registered nurse and a lifestyle support plan developed within three weeks of admission.

All five files (two rest home and three hospital) reviewed evidence that long-term support plans are evaluated at least three monthly for both rest home and hospital.

There is evidence that the overall support plans have been reviewed and documented in the evaluation section of each corresponding aspect of the lifestyle support plan.

The support plan evaluations indicate the degree of achievement of goals and objectives. Registered nurses, care workers, other health professionals (as appropriate) resident and family are involved at the time of support plan review. GP advised that resident reviews and medication chart reviews are conducted every three months or more frequently as required.

### **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:**

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There are comprehensive medication management policies and procedures in place. Medications are managed appropriately in line with accepted guidelines. The service uses four weekly blister pre-packed medication packs for all residents at Iona home and hospital. Medication charts have photo ID's. There is a signed agreement with the supplying pharmacy. Registered nurses advised that the list of medications printed on the back of medication packs are checked and reconciled against medication charts upon arrival to the facility by the night registered nurse and signed off when this check has been completed. The registered nurse was observed safely administering medications - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation. There is a list of standing order medications that have been approved by the GP's for each individual resident. Staff sign for the administration of medications on medication sheets held with the medicines. A list of specimen signatures and competencies is kept in the front of medication folders. There is a locked safe for controlled drugs. Controlled drug books shows evidence of two signatures for all controlled drug administration. Medication charts for 10 residents were reviewed. There is evidence of GP reviewing medication charts for each resident three monthly - confirmed at GP interview. . The service records all medication errors as incidents/accidents and these are followed up, reported in graph form, monthly and benchmarked with the other PSO facilities on a three monthly basis. Where PRN medication is used progress notes use the green stickers to document their use and effectiveness.</p> <p>The service has a policy and procedure on residents who wish to self-medicate that eludes three monthly assessment by GP of the resident's on-going ability to safely self-medicate and a resident competency review form. There are currently no residents self-medicating.</p> <p>D16.5.e.i.2: Ten medication charts were reviewed and identified that the GP had seen the resident three monthly and the medication chart was signed. 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) meets acceptable good practice standards.</p>

**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.

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

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

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

<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 1.3.12.6 (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> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
Holmdene kitchen provides food services for the residents of Holmdene, up to 40 meals on wheels per day and up to 16 residents in the attached rehabilitation service. The four weekly menu is designed by the organisation's dietitian and the kitchen has an HACCP food safety programme certificate and a certificate from the NZ food safety programme. The food service is notified of dietary requirements via a dietary requirements form, which is completed by the registered nurse and sent through to the kitchen. It includes likes and dislikes, modified diets and preferences. The service provides special equipment as required. A registered dietitian conducts nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues. Information is documented in the daily care interventions and in the integrated support plan if there is an identified nutritional issue. Resident weights are monitored monthly or more frequently if required.

Residents interviewed were complimentary of the food 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.

**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.

<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.)

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The facility displays a current building warrant of fitness, which expires September 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> (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>
There are policies around restraint, enablers and the management of challenging behaviours, which meet requirements of HDSS 2008. The service currently has no residents assessed as requiring restraint and no residents using enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. Restraint/enabler use is discussed at registered nurse and all staff meetings.
Staff received training around restraint minimisation and safe practice in November 2013. Management of challenging behaviours education was provided in November 2013. Restraint questionnaires and competency are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There are two resident with wrist alarms to alert staff when they leave the building. ( link to 1.3.6.1)

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the quality/CQI meetings and registered nurse meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager and to organisational management. There is a designated infection control nurse.

**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.

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