St John's Parish (Roslyn) Friends of the Aged and Needy Society

Current Status: 25 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

Leslie Groves Home and Hospital is owned and operated by St John's Roslyn Anglican church and is governed by a board of trustees. The service provides hospital/medical, psychogeriatric, dementia and rest home level care for up to 105 residents across two sites.

The Leslie Groves hospital facility has been undergoing a major staged refurbishment project over the past three years with an increase in resident room sizes, a new kitchen and laundry area, a new dementia unit and refurbishment of psychogeriatric and hospital areas.

The service is managed by an experienced principal nurse manager with support from a quality/clinical manager, unit managers and care staff. Staff interviewed and documentation reviewed identified that the service continues to implement systems that are appropriate to meet the needs and interests of the resident groups. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed five of five shortfalls from the previous verification audit relating to the completion of the building and approval of the fire evacuation scheme.

The service has addressed three of six shortfalls from the previous certification audit relating to safe storage of chemicals, medication storage and residents photographs on medication charts, and consent for enablers.

Further improvements continue to be required around documentation of advanced directives for all residents, completion of appropriate assessments to support care planning, and first aid training. This audit identified improvements required around further aspects of care planning, roster, medication management, and monitoring of enablers.

Audit Summary as at 25 March 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 25 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Organisational Management as at 25 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.

Continuum of Service Delivery as at 25 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 medium or high risk and/or unattained and of low risk.

Safe and Appropriate Environment as at 25 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Restraint Minimisation and Safe Practice as at 25 March 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

Infection Prevention and Control as at 25 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.

HealthCERT Aged Residential Care Audit Report (version 4.0)

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:	St John's Parish (Roslyn) Friends of the Aged and Needy Society
Certificate name:	St John's Parish (Roslyn) Friends of the Aged and Needy Society

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Leslie Groves Home; Leslie Groves Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	**Start date:** 25 March 2014 **End date:** 26 March 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:	100

Audit Team

Lead Auditor	XXXXX	**Hours on site**	13	**Hours off site**	7
Other Auditors	XXXXX	**Total hours on site**	13	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	3

Sample Totals

Total audit hours on site	26	Total audit hours off site	15	Total audit hours	41

Number of residents interviewed	6	Number of staff interviewed	17	Number of managers interviewed	3
Number of residents' records reviewed	10	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	20	Total number of staff (headcount)	90	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	4			Number of GPs interviewed	2

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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, 15 May 2014

Executive Summary of Audit

General Overview
Leslie Groves Home and Hospital is owned and operated by St John's Roslyn Anglican church and is governed by a board of trustees. The service provides hospital/medical, psychogeriatric, dementia and rest home level care for up to 105 residents across two sites. On the day of the audit, there were 100 residents – 32 rest home residents at the Leslie Groves home and 28 hospital, 17 dementia and 23 psychogeriatric residents at the Leslie Groves hospital. The Leslie Groves hospital facility has been undergoing a major staged refurbishment project over the past three years with an increase in resident room sizes, a new kitchen and laundry area, a new dementia unit and refurbishment of psychogeriatric and hospital areas. Stages one – nine are now complete. The service is managed by an experienced principal nurse manager with support from a quality/clinical manager, unit managers and care staff. Staff interviewed and documentation reviewed identified that the service continues to implement systems that are appropriate to meet the needs and interests of the resident groups. Family and residents interviewed all spoke very positively about the care and support provided. The service has addressed five of five shortfalls from the previous verification audit relating to the completion of the building and approval of the fire evacuation scheme. The service has addressed three of six shortfalls from the previous certification audit relating to safe storage of chemicals, medication storage and residents photographs on medication charts, and consent for enablers. Further improvements continue to be required around documentation of advanced directives for all residents, completion of appropriate assessments to support care planning, and first aid training. This audit identified improvements required around further aspects of care planning, roster, medication management, and monitoring of enablers.

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. The previous certification audit finding around advanced directives continues to require improvement. The complaints process and forms for completion are able to residents and family. Information relating to the Health and Disability Commissioner and advocacy service with contact details are also provided. Information on how to make a complaint and the complaints process are included in the admission booklet. Complaints are actively managed.

Outcome 1.2: Organisational Management
Leslie Groves Home and Hospital has a current business and quality plan to support quality and risk management. Quality information is gathered from internal audits, incidents and accidents, feedback from residents, family and staff. Data is collected and collated to provide opportunities for improvement. Corrective actions are implemented. Resident/relative surveys are undertaken annually. Adverse events are investigated and opportunities for improvement are actioned. Staff requirements are determined using a skill mix process and acuity levels and documented. Duty schedules are available for all shifts. There is an improvement required around the staffing roster. The service has a documented and implemented training plan.

Outcome 1.3: Continuum of Service Delivery

Care plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Care plans are evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available; however, the previous certification audit finding continues to require improvements. Improvements are also required in relation to documenting care plan interventions and content of care plan evaluations. Residents and family members interviewed stated that they are kept involved and informed about the resident's care.

The medication management system includes medication policy and procedures that follows recognised standards. Previous certification audit identified that aspects of medication management required improvement and this finding remains unmet. Improvements are required whereby all staff responsible for medication administration are assessed as competent. Resident medications are reviewed by the residents' general practitioner at least three monthly.

A range of activities are available and residents provide feedback on the programme. Leslie Groves has food policies/procedures for food services and menu planning appropriate for this type of service.

Food services are contracted to a food service company who work from the Leslie Groves hospital site kitchen and transport meals to the rest home. Nutritional and safe food management in-service is completed by staff. 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

Leslie Groves home and hospital each have a current building warrant of fitness. The rest home building warrant of fitness expires on 16 May 2014. The hospital has addressed the previous verification audit finding around certificate of public use and now has a current building warrant of fitness, which expires on 16 March 2015. Previous certification audit finding related to safe chemical storage has been addressed and monitored. The shortfall around providing a certificated first aid training course for staff remains an area for improvement.

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 11 hospital residents assessed as requiring bedrails as falls prevention measures (enablers), one psychogeriatric resident with bedrails and one rest home resident with bedrails. There is a restraint register and enablers register. Staff receive training in restraint minimisation and challenging behaviour management. Competencies are also completed.

Improvement is required around monitoring and recording of enabler for the rest home resident.

Outcome 3: Infection Prevention and Control

The infection control nurse (quality/clinical manager) at Leslie Groves Home and Hospital 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

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	12	0	2	6	0	0
Criteria	0	36	0	2	7	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	30
Criteria	0	0	0	0	0	0	0	56

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S .2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Moderate			
HDS(C)S .2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Moderate	The service does not provide opportunity for discussion with residents and families in relation to resuscitation due to the 'no CPR' policy currently in force at Leslie Groves. The service's position on 'no CPR' is discussed prior to admission, whereby prospective residents and families are informed of the 'no CPR' policy. Residents and families are, therefore, left with no option than to accept this policy or find alternative accommodation.	The service should review their policy, practice and approach to residents' resuscitation status to ensure that the Code of Health and Disability Services Consumers' Rights are adhered to in relation to advanced directives.	60
HDS(C)S	Standard	Consumers receive timely,	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
.2008	1.2.8: Service Provider Availability	appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.				
HDS(C)S .2008	Criterion 1.2.8.1	There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	Contractual requirements are not met in regards to the hospital unit at Leslie Groves hospital. There is a registered nurse on duty from 7am – 3pm and 3pm – 11pm. There is no rostered RN on duty overnight in the hospital unit (as per ARC D17.4a.i.). Advised the RN is shared from the PG unit.	Ensure that staffing levels meet contractual requirements within the hospital unit.	30
HDS(C)S .2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S .2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Assessment documentation has not been completed for the following residents: a) falls risk, continence, pain or pressure area assessment for a resident in the hospital that was recently admitted b) continence assessment for four residents -two resident in the PG unit and two resident in the rest home with change in continence needs; c) nutrition/dietary assessment for a resident with swallowing problems in the dementia unit; d) behaviour assessment for a resident in the rest home with wandering behaviour.	Ensure assessments are conducted for all identified needs to support the development of care plans and service delivery.	60
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 Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Moderate	Three of the rest home files sighted; interventions are recorded in the evaluations and progress notes and not transferred to the body of long term care plan. Four (one of the hospital, one of the dementia and two of the PG unit) do not have detailed interventions recorded to guide the staff: a) the initial care plan for the hospital resident's wound management needs do not have the frequency of wound dressing changes or renew dates of the dressing changes recorded; b) the resident in the dementia unit presents with challenging behaviour; however no individualised management strategies are recorded on the long term care plan; c) one resident in the PG unit has interventions recorded on the falls risk assessment and not transferred to the body of the long term mobility care plan; d) another resident in the PG unit has a wound assessment /care plan with no review date ,frequency of dressing changes or outcome recorded.	Ensure that interventions are (a) entered into the care plans, and (b) are detailed, to guide staff	60
HDS(C)S .2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S .2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	(i)Three of three rest home residents` files evidence that progress different from the expected goal are documented in the evaluation section and not transferred to the body of the long term care plan: a) one resident is evaluated to need supervision when toileting however the long term care plan stated that she needs	(i)Ensure that the long term care plan reflect any changes to interventions and goals if the progress be different from the outcome. (ii) Ensure that short term care plans are utilised for all acute or short term issues.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				no supervision; b) one resident is evaluated to need a commode for toileting needs however the long term care plan states she is toileting independently c) one resident was evaluated with change in behaviour however the long term care plan do not reflect the changes in intervention on the cognitive/behaviour plan. (ii)Short term care plans are in place on five residents' files for short term changes in condition; however five of the files evidence that short term care plans are not used to document short term and acute issues or the LTCP updated: a) hospital resident with wound management; b) PG resident with a current skin condition; c) dementia unit resident with a current urinary tract infection(UTI); d) two rest home residents –one with a current UTI and one with a wrist fracture and current UTI.		
HDS(C)S .2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S .2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	a)Stock checks of controlled drugs are conducted by two staff members at random intervals – not routinely on a weekly basis; b) it was noted that five (hospital) of the twelve medication signing sheets reflect a failure to include a signature after medication administration; c) seven eye drop containers in the hospital medication trolley reflect no date and time of opening the container; d) weekly controlled drug checks have not	a)Conduct weekly documented checks of controlled drugs as per guidelines; b) ensure that all medications administered are signed for; c) ensure that eye drop medications are dated at time of opening; d) conduct weekly controlled drug checks as per guidelines; e) cease the practice of the RN checking out controlled drugs for weekend	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				been conducted in either the hospital and rest home CD register; e) controlled drug medications in the rest home are checked out by the RN on a Friday - prior to administration by the caregivers over the weekend; f) the CD register in the hospital shows three places where a second signature omits; g) the medication packs are not checked against the medication charts in either the hospital or rest home upon arrival to the facility as per accepted best practice.	administration by care givers; f) ensure that the CD register evidence two staff signatures; g) ensure that there is evidence that medication are checked against the medication charts upon arrival to the facility.	
HDS(C)S .2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	On review of the medication competency register, and on discussion with the quality manager, it is noted that medication competencies for some staff have expired. On review of two registered nurse staff files it is noted that medication competencies have not been conducted and syringe driver training and competency has expired. One rest home caregiver file evidenced medication competency last conducted in 2011.	Ensure that medication competencies are conducted annually for all staff that have responsibilities for administering medications.	30
HDS(C)S .2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate			
HDS(C)S .2008	Criterion 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Moderate	First aid training is not provided by a certified trainer. CPR training is not provided for staff.	Provide evidence that staff complete a certified first aid course and CPR course to ensure that there is at least one staff member on each shift on each site with a current first aid certificate.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 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.	PA Low	Monitoring of an enabler in the rest home is not recorded.	Ensure all documentation and records are completed for enabler use.	90

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 in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or the registered nurses and a copy of any incident relating to individual residents is included in the clinical file. Progress notes records that families are informed following general practitioner (GP) review, incidents or accidents or if there is a change in resident condition (confirmed by six relatives interviewed – three PG, one dementia, one hospital and one rest home). Interviews with the rest home nurse manager, the hospital clinical leader, the dementia unit manager, one PG RN, one rest home RN and two enrolled nurses all stated that they are to record contact with family/whanau in resident files. Incident forms have a section to indicate if family/whanau have been informed of an incident/accident. Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in the manager's office in the both the home and hospital and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet. Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet. 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. Residents (six – two hospital and four rest home) and six relatives interviewed, confirmed they are kept fully informed. 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:

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 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

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

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

Attainment and Risk:	PA Moderate
Evidence:	

Previous certification audit identified that the service should review the documentation for advanced directives and the service's approach to resident's 'resuscitation status' to align with good practice. The service has policy and procedure relating to informed consent and residents or their EPOA sign that they consent to areas of care and services, information storage and accessibility, photographs and that they are aware of the service's policy regarding no CPR provided. The service has made an addition to the informed consent form to include: "Resuscitation: I have been informed of and have had opportunities to discuss the policy that Leslie Groves has in regard to CPR. I understand that Leslie Groves does not offer CPR".
Advised by the principal nurse manager that they have not changed their position on 'no CPR', and that all prospective residents and families are informed of this policy prior to admission. The service does not utilise resuscitation orders (due to the 'no CPR' policy) and does not provide discussion and options for residents and families. The service has a philosophy of 'palliative care' where they feel that a 'no resuscitation' policy fits. The service believes that by informing prospective resident and

families of the no CPR policy prior to admission, then they have met their obligations on informed consent. Improvements continue to be required in this area. Staff have not received first aid training or CPR training via a certified training course (link #1.4.7.2).

Since the draft report the provider advised "The information as presented above fails to represent the intent of the policy and inaccurately describes the process that occurs (e.g.there is opportunity for discussion). The service philosophy has a palliative approach which we believe does align with good practice. The policy has developed after years of revision, following evidence based documents e.g Australian Guidelines for a Palliative Approach in Aged Residential Care 2006 and in association with the General Practitioner who supports the service. To say that "no CPR fits with palliative care" appears flippant and does not reflect the commitment to providing appropriate services for the people who are admitted into the service. We believe that offering CPR is not an appropriate treatment option, just as cardiac surgery would not be offered to residents living in our facilities. We believe that this policy is honest, open and transparent unlike other facilities that may provide a form to be signed, which we all know that in reality is unlikely to be discussed fully or actioned in the event of a cardiac arrest. As the signed consent form confirms, there are opportunities to discuss the fact that Leslie Groves does not offer CPR. These discussions take place before residents or families choose to accept a bed in the facility. There is signed confirmation that the discussions take place and acceptance of the policy on the pre-admission enquiry form, the service agreement and the consent form. This discussion is not just about CPR but facilitates positive and open attitudes towards death and dying. We do believe that residents / families are fully informed prior to admission".

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

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

Attainment and Risk: PA Moderate

Evidence:

Previous certification audit identified that the service should review the documentation for advanced directives and the service's approach to resident's 'resuscitation status' to align with good practice. The service has policy and procedure relating to informed consent and residents or their EPOA sign that they consent to areas of care and services, information storage and accessibility, taking of photographs and that they are aware of the service's policy regarding 'no cardio pulmonary resuscitation (CPR)' is provided. Advised by the principal nurse manager that they have not changed their position on 'no CPR', and that all prospective residents and families are informed of this policy prior to admission. They advised that they questioned their position and informally consulted with members of the DHB and MOH. They read further in effort to support their stance or change direction. However, their decision was to continue with the policy. The consent form was reviewed to provide more robust evidence that the resident / family are fully informed and accepting of the policy and that the service does provide opportunities for discussion and an additional sign off was added to the pre-admission enquiry form. Residents who may have been admitted previous to the policy change were re-visited to ensure they were aware of the policy.

Residents and relative surveyed in August 2013 were asked the question if they were comfortable with the policy that no CPR is provided to residents who suffer a cardiac arrest. The majority of responses were affirmative, however, two responses (4.5%) stated otherwise that a) would like them to try if there is a chance, and b) depending on age and condition. One of six family members interviewed advised that they were not comfortable with the policy, but had no alternatives for dementia care, so accepted the bed for the resident. On review of one hospital resident's file, an advanced care directive is signed by the resident (this was a document from a previous provider) and indicates that the resident would like CPR to be attempted. The resident is very unwell and unable to discuss the current CPR status, however discussion has been held with the family. The service does not utilise resuscitation orders (due to the 'no CPR' policy) and therefore does not provide evidence or record of discussion and options for residents and families in the event of cardiac arrest. The service has a philosophy of 'palliative care' where they feel that a 'no resuscitation' policy fits. The service believes that by informing prospective resident and families of the 'no CPR' policy prior to admission, then they have met their obligations on informed consent and more broadly, aligns with the code of consumer rights.

Finding: The service does not provide opportunity for discussion with residents and families in relation to resuscitation due to the 'no CPR' policy currently in force at Leslie Groves. The service's position on 'no CPR' is discussed prior to admission, whereby prospective residents and families are informed of the 'no CPR' policy. Residents and families are, therefore, left with no option than to accept this policy or find alternative accommodation.
Corrective Action: The service should review their policy, practice and approach to residents' resuscitation status to ensure that the Code of Health and Disability Services Consumers' Rights are adhered to in relation to advanced directives.
Timeframe (days): 60 *(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: The complaints process and forms for completion are available at the reception of both the home and the hospital. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The electronic complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. The principal nurse manager maintains the records of all complaints that are processed as evidenced by the six resident related complaints received for 2013. Details of the management of the complaints are recorded including letters of follow up, meetings and response. Complaints are discussed at the monthly quality meetings, and at the general staff meetings. A complaints procedure is provided to residents within the information pack at entry. Six residents and six family members interviewed were aware of the complaints process and advised that management is approachable and responsive to any issues or areas of concern.

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: Leslie Groves Home and Hospital is owned and operated by St John's Roslyn Anglican church and is governed by a board of trustees. Day to day management is provided by a principal nurse manager who reports to the board. The principal nurse manager (PNM) is a registered nurse who maintains an annual practicing certificate. She is experienced in aged care and has been manager of Leslie Groves Home and Hospital for over 10 years. The principal nurse manager reports to the board on areas relating to health and safety, quality, achievement with key performance indicators, repairs and maintenance, wages, rostering and staffing, and occupancy. The service has an operations quality plan for 2014, which includes the quality and risk management programme, occupancy, staffing and service levels. A quality management system is implemented which includes gathering data and information to provide opportunities for quality improvement. The organisation has a mission

statement and documented philosophy of care.
The principal nurse manager has attended in excess of eight hours of professional development in the past 12 months relating to managing the facility and includes attending aged care conference, attending internal and external meetings and maintaining nursing professional development.

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: FA

Evidence:

Leslie Groves Home and Hospital has a current operation quality programme for 2014, which includes the mission and philosophy of service, a quality policy statement and objectives. The quality programme objectives consists of, care services, human resources, health and safety, risk management, building and maintenance, marketing, quality and financial. Hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.
Progress with the operations quality plan (OpQual plan) is monitored through the twice monthly management meetings, monthly unit staff meetings, and various monthly staff meetings. A three monthly progress report is conducted by the quality manager (March 2014) and an annual comprehensive review is conducted (last conducted Jan 2014). The annual review involves review of objectives and updates on the actions taken.
The management meeting agenda and minutes includes maintenance, staffing and rosters, incidents and accidents, medications, complaints, employment, health and safety, clinical, quality, staff training, interRAI updates and progress of the OpQual plan (sighted for 26 February 2014).
The monthly health and safety/infection control meeting agenda includes review of the risk management plan. Minutes from meetings are available for staff to read in the staff room. Registered nurses meet fortnightly and there are unit meetings held each month in the rest home and hospital. Other department meetings also occur for housekeeping, night staff, and activities. All meeting minutes have a corrective action format and include actions to achieve compliance where relevant. This, together with staff training, demonstrates Leslie Groves on-going commitment to continuous quality improvement. Discussions with registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly in the hospital unit and two monthly in the rest home with laundry, activities and food/meals as regular agenda items. Minutes sighted for February 2014 for both areas.
There is an internal audit schedule completed for 2013 for both rest home and hospital and in progress for 2014. It includes (but is not limited to): documentation, resident files, pressure area risk assessments, medical and medications, hot water temperatures, health and safety, medication administration, admission checklists, infection control, hand hygiene, laundry, restraint, nutrition, food service, cleaning and staff orientation. There is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. These are signed off by the quality manager when completed. Corrective actions are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions.

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.
The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the resident care plans. The management committee is responsible for development and review of policies and procedures and includes the principal nurse manager, quality manager, unit managers and clinical team leaders. 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 and implemented risk management, health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family,

physiotherapy assessment, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.
The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by caregivers and given to the registered nurses who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the quality manager and principal nurse manager who completes any additional follow up. The quality manager collates and analyses data to identify trends. Results are discussed with staff through the management and staff meetings.
A resident/relative survey is conducted annually. Residents and families are surveyed privacy, activities, diet and food, environment, communication, care delivery, involvement in care planning, consumer rights, medical, laundry, concerns/complaints, and the facilities CPR policy (link #1.1.10). The surveys reviewed evidence that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via the facility newsletter and meetings.

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: 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 1.2.3.7 (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: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at the fortnightly management meetings, monthly staff meetings and monthly health and safety/infection control meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

There is an open disclosure policy and six family members interviewed (three PG, one dementia, one hospital and one rest home) stated they are informed of changes in health status and incidents/accidents. A sample of incident forms for each unit (PG, dementia, hospital and the rest home) were reviewed January and February 2014. November 2013 were reviewed and involved five hospital residents, three PG residents, three dementia and two rest home. The incidents included behaviours, falls, and skin tears. 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 each unit manager, quality manager and principal nurse manager. Referral to general practitioner, needs assessment, nurse practitioner and other allied health has been instigated as required. Medication errors are also reported.
A monthly incident trend analysis and annual incident trend analysis is conducted with reviews and summaries is compiled by the quality manager and principal nurse manager with subsequent analysis and investigations. Analysis occurs around falls, skin tears, challenging behaviours, environment and equipment, medications, infections, complaints and acuity levels of residents. Incidents and accidents are reported in progress notes and communication with family regarding incidents is also recorded. Staff have received education regarding open disclosure, incident reporting and communication with families.

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: 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, general practitioners, podiatrist, physiotherapist and pharmacists is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed for rest home and hospital staff (one clinical leader RN, one registered nurse, and five caregivers). Advised that reference checks are completed before employment is offered as evidenced in two recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Seven caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in seven of seven staff files reviewed. Discussion with the management and staff confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and a plan in progress for 2014. The annual training programme exceeds eight hours annually. Care givers working in the dementia unit and psychogeriatric unit have either completed the required dementia unit standards or are working towards completion. Nine new staff in the PG unit and three new caregivers in the dementia unit are yet to start the course. The principal nurse manager, clinical manager and registered nursing staff attend external training including conferences, seminars and sessions provided by the local DHB. Education is provided for staff in the rest home and hospital with similar topics presented either as combined in-service education or on separate days. A record is kept of staff attendance to ensure that all staff attend the compulsory in-service sessions such as fire training, and manual handling. Education provided in 2013 includes but not limited to: fire training and emergency management, wound management, behaviour management, safe food handling, activities, chemical safety, dementia, medications, and moving and handling. Fire evacuation drill last conducted in hospital area on 23 December 2013, and in the rest home on 14 January 2014. Annual appraisals are conducted for all staff as evidenced in seven of seven files reviewed.

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: PA Low
Evidence: Human resource management policies includes a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home facility and the hospital, and dementia residents at Leslie Groves hospital. The hospital unit at Leslie Groves hospital has a registered nurse on duty in the morning and afternoon shift but not overnight. Improvements are required in this area. In the rest home, a minimum of two care staff are rostered on at any one time with a registered nurse on duty from Monday to Friday and on-call afterhours and on weekends. There is a full time nurse manager in the rest home. On-call is shared by the nurse manager, quality manager (RN) and clinical leader from the hospital unit. In the psychogeriatric unit, there is a registered nurse on duty 24/7 who also provides cover for the dementia unit. The hospital unit has a clinical leader (RN) who works Monday to Friday. The psychogeriatric night duty registered nurse provides cover to the dementia and hospital units after hours. The hospital unit has a registered nurse on duty am and pm shift. The PG unit manager is an occupational therapist. There is an enrolled nurse on duty in the dementia unit on every shift. Either the quality manager (RN) or another RN is assigned to conduct the initial InterRAI assessment. The EN documents the care plan and the RN counter signs this and all other assessments, updates and evaluations. Advised by one enrolled nurse interviewed from the dementia unit that registered nurse input occurs at least daily to discuss residents with complex needs. Caregivers cover a mixture of short and long shifts for morning and afternoon shifts and there is one caregiver on duty in each unit overnight (as well as the RN). Activities staff are employed in each area with Monday to Sunday activities provided in the dementia and PG units. Roster includes the principal nurse manager 40 hours per week, quality manager 40 hour per week, a clinical leader in the hospital unit, registered and enrolled nurses on each shift and caregiving staff who work short and long shifts in each area. The service also employs laundry staff, cleaning staff, cook and kitchen hands and a maintenance person and gardeners. Interviews with the principal nurse manager, quality manager, registered nurses, enrolled nurses, caregivers, six residents and six

family members identify that staffing is adequate to meet the needs of residents with occasional shortfalls due to inability to replace staff at short notice.

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

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

Attainment and Risk: PA Low
Evidence: Human resource management policies includes a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home facility and the hospital, and dementia residents at Leslie Groves hospital. In the rest home, a minimum of two care staff are rostered on at any one time with a registered nurse on duty from Monday to Friday and on-call afterhours and on weekends. There is a full time nurse manager in the rest home. On-call is shared by the nurse manager, quality manager (RN) and clinical leader from the hospital unit. In the hospital facility, there is a registered nurse on duty in the hospital unit am/pm shift. The hospital unit has a clinical leader (RN) who works Monday to Friday. The psychogeriatric night duty registered nurse provides cover to the dementia and hospital units overnight. The hospital unit has a registered nurse on duty am and pm shift. The PG unit manager is an occupational therapist. There is an enrolled nurse on duty in the dementia unit on every shift with oversight and care plan development and review provided by either the RN or the quality manager (RN). Caregivers cover a mixture of short and long shifts for morning and afternoon shifts and there is one caregiver on duty in each unit overnight (as well as the RN). Activities staff are employed in each area with Monday to Sunday activities provided in the dementia and PG units.
Finding: Contractual requirements are not met in regards to the hospital unit at Leslie Groves hospital. There is a registered nurse on duty from 7am – 3pm and 3pm – 11pm. There is no rostered RN on duty overnight in the hospital unit (as per ARC D17.4a.i.). Advised the RN is shared from the PG unit.
Corrective Action: Ensure that staffing levels meet contractual requirements within the hospital unit.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Each stage of the assessment, planning, and provision of care and review is undertaken by staff that are competent to perform their duties. Ten of the ten resident`s files reviewed confirm that the registered nurse (RN) conducts the initial assessment and initial care plan on admission to the service and develops the long term care plan within three weeks. The service is currently in the process of integrating InterRAI with their current documentation system. The clinical coordinator is fully trained in interRAI.
The following files were sampled and reviewed: three from the rest home, three from the hospital, two from the dementia unit and two from the psychogeriatric (PG) unit. Initial admission profile and care summary are completed on admission and include areas of cognitive status/communication; mood/behaviour, psychosocial /wellbeing, activities of daily living, functional status/mobility, continence, progressive disease management. Contact and family/whānau involvement is maintained and sighted in all ten residents' files. The plans are evaluated and interventions updated six monthly or more frequently as the resident needs changes. Evaluation includes consultation with the resident, the multidisciplinary team, resident`s family and/or whānau. Family are invited to attend the care planning update. Progress notes are comprehensive, reflect any changes and signed by the person entering them.

Risk assessments such as continence, pain, pressure injury, falls, dietary and if required behaviour risk assessments are conducted on admission to the facility.
GP notes reviewed show three monthly reviews by the GP or more often as required. The handovers are verbal and promotes continuity between shifts. Three caregivers interviewed confirmed that they are encouraged to read the progress notes and care plans of each resident. Two of two GP interviewed via phone reports that in their opinion, the care provided to residents is of a very good standard.

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

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

Rest Home resident tracer methodology:

Dementia unit resident tracer methodology:
XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

The AARC requirements are met.

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 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: PA Moderate

Evidence:

Previous audit identified improvement was required in relation to the use of assessment documentation to further support the development of care plans and delivery of care. A range of assessment tools are completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) pain assessment, e) skin assessment, f) and nutritional assessment. BP`s and weights are recorded on a weekly to monthly basis dependant on the needs of the resident. Residents and family members interviewed are satisfied with the support provided.
Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. Assessment and documentation are not always completed or put in place when indicated by the residents` condition. Three (two of the hospital and one of the dementia unit) of the ten files reviewed are comprehensive; with InterRAI initial assessments, other additional assessments, care plans and re-assessments fully integrated with the current documentation system. Assessment tools are used; evaluated six monthly and guide the care plans. A registered nurse completes the assessments in conjunction with the resident and family involvement.

Seven(one of the hospital, one of the dementia unit, two of the PG unit and three of the rest home) of the ten residents` care plans evidence assessment tools are not utilized consistently to identify residents` needs or a change in needs. This remains an improvement from the previous certification audit.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: PA Moderate

Evidence:

A range of assessment tools are completed in resident files on admission and updated at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) pain assessment, e) skin assessment, f) and nutritional assessment.
Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. Assessment and documentation are not always completed or put in place when indicated by the residents` condition. Three (two of the hospital and one of the dementia unit) of the ten files reviewed are

comprehensive; with InterRAI initial assessments, care plans and re-assessments fully integrated with the current documentation system. Assessment tools are utilised, evaluated at least six monthly and guide the care plans.
Seven of the ten residents` care plans evidence assessment tools are not utilised consistently to identify residents` needs or a change in needs.

Finding:

Assessment documentation has not been completed for the following residents: a) falls risk, continence, pain or pressure area assessment for a resident in the hospital that was recently admitted; b) continence assessment for four residents -two resident in the PG unit and two resident in the rest home with change in continence needs; c) nutrition/dietary assessment for a resident with swallowing problems in the dementia unit; d) behaviour assessment for a resident in the rest home with wandering behaviour.

Corrective Action:

Ensure assessments are conducted for all identified needs to support the development of care plans and service delivery.

Timeframe (days): 60 *(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 Moderate

Evidence:

Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services, this includes a range of nurse specialists from the DHB, dietician and speech language therapist. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement. Residents interviewed confirm their current care and treatments meet their needs. Contact with family is recorded in the progress notes, sighted in all ten residents' files reviewed.

Three (two in the hospital and one in the dementia unit) of ten residents' files reviewed provide evidence care plans record appropriate interventions that are based on the assessed needs, desired outcomes or goals of the residents. The long term care plans records the identified need, level of assistance required and desired outcomes or goals that are individualised to the resident's needs. The required care, direction, or supervision of a resident is recorded in the body of the care plan, dated and signed for by the person entering a change to the interventions; however in three of the rest home files sighted the interventions are recorded in the evaluations and progress notes and not transferred to the body of long term care plan.

Four (one of the hospital, one of the dementia and two of the PG unit) of the ten care plans reviewed do not have detailed interventions recorded to guide care staff. For example – The initial care plan for the hospital resident's wound management needs do not have the frequency of wound dressing changes or renew dates of the dressing changes recorded. The resident in the dementia unit presents with challenging behaviour; however, no individualised management strategies are recorded on the long term care plan.
One resident in the PG unit has interventions recorded on the falls risk assessment and not transferred to the body of the long term mobility care plan. Another resident in the PG unit has a wound care assessment with no review date, frequency of dressing change or outcome recorded.
There was evidence of a documented surgical wound and three skin tears in the hospital. There are no pressure area wounds reported in any of the units.

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 Moderate

Evidence:

The required care, direction, or supervision of a resident is recorded in the body of the care plan, dated and signed for by the person entering a change to the interventions; however in three of the rest home files sighted the interventions are recorded in the evaluations and progress notes and not transferred to the body of long term care plan.
Four (one of the hospital, one of the dementia and two of the PG unit) of the ten care plans reviewed do not have detailed interventions recorded to guide care staff. For example – The initial care plan for the hospital resident's wound management needs do not have the frequency of wound dressing changes or renew dates of the dressing changes recorded. The resident in the dementia unit presents with challenging behaviour; however, no individualised management strategies are recorded on the long term care plan.
One resident in the PG unit has interventions recorded on the falls risk assessment and not transferred to the body of the long term mobility care plan. Another resident in the PG unit has a wound care assessment and care plan with no review date, frequency of dressing change or outcome recorded.

Finding:

Three of the rest home files sighted; interventions are recorded in the evaluations and progress notes and not transferred to the body of long term care plan.

Four (one of the hospital, one of the dementia and two of the PG unit) do not have detailed interventions recorded to guide the staff: a) the initial care plan for the hospital resident's wound management needs do not have the frequency of wound dressing changes or renew dates of the dressing changes recorded; b) the resident in the dementia unit presents with challenging behaviour; however no individualised management strategies are recorded on the long term care plan; c) one resident in the PG unit has interventions recorded on the falls risk assessment and not transferred to the body of the long term mobility care plan; d) another resident in the PG unit has a wound assessment /care plan with no review date ,frequency of dressing changes or outcome recorded.

Corrective Action:

Ensure that interventions are (a) entered into the care plans, and (b) are detailed, to guide staff

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

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

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

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

Attainment and Risk: FA
Evidence: Two diversional therapists (DT) and two activities co-ordinator interviewed confirm the activities programme aim to promote a friendly, warm and interactive environment that facilitates socialisation. The programme includes a variety of physical, mental, group and individual activities and is conducted over a minimum of five days a week. The activity staff interviewed confirm that they feel supported by other care staff and management and that they participate in the six monthly multidisciplinary reviews of the residents. In the dementia unit and PG unit there is one activity staff member for each unit who covers Monday to Friday (30 hours) - this include some van driving duties. Another activity staff member covers Thursday to Sunday (15 hours) until 6 pm. Information regarding each resident's activity needs, choices and preferences is gathered on admission and regularly reviewed thereafter. Relevant information is shared with members of the multidisciplinary team. Documentation identifies that the activities co-ordinators gain an understanding of a residents' preferred use of time and develops an individual plan that meets their needs, abilities and preference. One on one activities are also provided as required for residents who do not prefer to participate in group activities. The activities co-ordinators explained how information is sought for each resident, inclusive of choices of activities they enjoy, risk factors with health status, social information, specific health concerns, physical/functional state, interests, hobbies, church affiliations, other relative information and especially their life history. This information forms the basis of developing the resident's activities plan to maintain the resident's strengths and interests. The resident's individual plans sighted are reviewed six monthly, signed and dated by the activities co-ordinator and registered nurse. The activities plans are displayed in each wing, the lounge and dining room notice boards. Attendance records sighted are maintained. The activity programme is coordinated in conjunction with volunteers and visiting entertainers. The activities plan sighted is meaningful, motivating and maintains the special interests of residents. . Residents interviewed report that they are satisfied with the variety of planned activities. Activities are provided in both the hospital unit and PG unit, for six hours per day Monday to Friday. In the Dementia unit, activities are provided

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: Nine of ten residents' files reviewed provide evidence that evaluations of care plans indicate the degree of achievement towards meeting the goals. One resident is a recent admission and evaluation of their care plan is not due. Three of the rest home residents have six monthly evaluations however, these include interventions toward the goal. Multidisciplinary reviews of care are current. Residents and family members interviewed confirm that they are involved in the review of the care of their relative. The two GPs confirmed that they are invited to attend multidisciplinary meetings but due to time constraints, they are not able to. The GP review residents medical condition three monthly or more frequently if necessary; medication charts are reviewed three monthly. Residents and family interviewed confirm they are involved in reviews of care; however, there is evidence that residents or family have input into the six monthly care plan evaluations. Residents' files evidence referral letters to specialists and other health professionals. One hospital resident was referred to a wound care specialist, dietitian and vascular clinic. Short term care plans are in place on five residents' files for short term changes in condition; however five of the files evidence that short term care plans are not always used to document short term and acute issues: a) resident in the hospital do not have a short term care plan for wound management; b) resident in the PG unit do not have a short term care plan for a skin condition; c) one resident in the dementia unit does not have a short term care plan for a urinary tract infection; d) one resident in the rest home with urinary tract infection ;e) one resident in the rest home with a wrist fracture and urinary tract infection.

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: PA Moderate
Evidence: Nine of ten residents' files reviewed provide evidence that evaluations of care plans indicate the degree of achievement towards meeting the goals. One resident is a recent admission and evaluation of their care plan is not due. Three of the rest home residents have six monthly evaluations however; the evaluations include interventions toward the goals. Goals are measurable, resident focussed and realistic. Multidisciplinary reviews of care are current. Residents and family members interviewed confirm that they are involved in the review of the care of their relative. The two GP`s confirmed that they are invited to attend multidisciplinary meetings but due to time constraints they are not able to. The GP review residents medical condition three monthly or more frequently if necessary; medication charts are reviewed three monthly. Residents and family interviewed confirm they are involved in reviews of care; however, there is evidence that residents or family have input into the six monthly care plan evaluations. Residents' files evidence referral letters to specialists and other health professionals. One hospital resident was referred to a wound care specialist, dietitian and vascular clinic. Short term care plans are in place on five residents' files for short term changes in condition; however five of the files evidence that short term care plans are not always used to document short term and acute issues
Finding: (i)Three of three rest home residents` files evidence that progress different from the expected goal are documented in the evaluation section and not transferred to the body of the long term care plan: a) one resident is evaluated to need supervision when toileting however the long term care plan stated that she needs no supervision; b) one resident is evaluated to need a commode for toileting needs however the long term care plan states she is toileting independently c) one resident was evaluated with change in behaviour however the long term care plan do not reflect the changes in intervention on the cognitive/behaviour plan. (ii)Short term care plans are in place on five residents' files for short term changes in condition; however five of the files evidence that short term care plans are not used to document short term and acute issues or the LTCP updated: a) hospital resident with wound management; b) PG resident with a current skin condition; c) dementia unit resident with a current urinary tract infection(UTI); d) two rest home residents –one with a current UTI and one with a wrist fracture and current UTI.
Corrective Action: (i)Ensure that the long term care plan reflect any changes to interventions and goals if the progress be different from the outcome. (ii) Ensure that short term care plans are utilised for all acute or short term issues.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. The facility used a robotic system that is delivered by the pharmacy every 28 days. Advised that the content of packets or blisters is checked by the nurses in the hospital against the medication chart at the point of administration and at the rest home the packs are checked on delivery as described above. Improvements are required in this area.

The nurse manager in the rest home confirms that monthly medication audits are completed which include checking the first ten medication sachets against the resident medication chart. Any errors by the pharmacy are regarded as an incident.
Registered nurses are responsible for the administration of medication in the rest home, hospital and PG unit. The enrolled nurse (unit manager) is responsible for medication administration in the dementia unit and care staff are responsible for medication administration over the weekend in the rest home. A register in each medication file shows signatures and initials to identify the administering staff member.
Staff interviewed that they do medication competencies that include syringe driver competency and insulin competency; however the register evidence that medication competencies have either expired or either not completed. This area requires improvement.

Resident medication charts are identified with demographic details and photographs. The fridge in the hospital and rest home has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record.

All 16 medication charts sampled had allergies (or nil known), documented and PRN medication charted to a detailed level. All medication charts (16 of 16) reviewed have PRN medications charted with frequency or maximum dose charted. Regular medications charted have not always been signed as administered. Five of the sixteen charts reviewed shows gaps on the administration records. Seven eye drop containers in the hospital trolley are not dated with an opening date; however all five eye drop containers in the rest home medication trolley are dated. These are areas requiring improvement.
There are medication trolleys that are kept in the clinical rooms, which are locked when not in use.
There is a locked cupboard that is used for controlled drugs. In the hospital and the rest home the weekly controlled drugs (CD) checks have not always occurred. The running stock has been maintained and signed by a registered nurse and the pharmacist. The nurse manager in the rest home confirmed that the RN checked and signed CDs on a Friday prior to administration over the weekend; the CDs are then stored in another locked cupboard. This practice occurs for weekend administration of CDs by the caregivers. The CD register in the hospital shows three gaps in the administration register where only one signature appears. These are areas that require improvement.

Medication round observed; all practice is appropriate.
The nurse manager in the rest home confirms that there are no residents self-medicating.
Sixteen medication charts reviewed identified that the GP had seen and 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: PA Moderate
Evidence: There are policies and processes that describe medication management that align with accepted guidelines. The facility used a robotic system that is delivered by the pharmacy every 28 days. The registered nurse in the hospital and the PG unit interviewed confirm that they check the medication with the medication charts on arrival from the pharmacy; however, there is no record that this is occurring. The nurse manager in the rest home confirms that monthly medication audits are done which include checking the first ten medication sachets against the resident medication chart. Any mistakes by the pharmacy are regarded as an incident. There are medication trolleys that are kept in the clinical rooms, which are locked when not in use. There is a locked cupboard that is used for controlled drugs. Sixteen medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. Resident medication charts are identified with demographic details and photographs. The fridge in the hospital and rest home has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record.
Finding: a)Stock checks of controlled drugs are conducted by two staff members at random intervals – not routinely on a weekly basis; b) it was noted that five (hospital) of the twelve medication signing sheets reflect a failure to include a signature after medication administration; c) seven eye drop containers in the hospital medication trolley reflect no date and time of opening the container; d) weekly controlled drug checks have not been conducted in either the hospital and rest home CD register; e) controlled drug medications in the rest home are checked out by the RN on a Friday - prior to administration by the caregivers over the weekend; f) the CD register in the hospital shows three places where a second signature omits; g) the medication packs are not checked against the medication charts in either the hospital or rest home upon arrival to the facility as per accepted best practice.
Corrective Action: a)Conduct weekly documented checks of controlled drugs as per guidelines; b) ensure that all medications administered are signed for; c) ensure that eye drop medications are dated at time of opening; d) conduct weekly controlled drug checks as per guidelines; e) cease the practice of the RN checking out controlled drugs for weekend administration by care givers; f) ensure that the CD register evidence two staff signatures; g) ensure that there is evidence that medication are checked against the medication charts upon arrival to the facility.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: PA Moderate
Evidence: Caregivers, who have completed competency, administer medications at rest home level care. Registered nurses and enrolled nurses are responsible for medication administration at hospital level care. Caregivers are required to repeat medication competencies annually. However, nurses complete competencies on orientation but are not expected to repeat this annually.

Registered nurses interviewed stated that they do complete medication competencies that include syringe driver competency and insulin competency.
Finding: On review of the medication competency register, and on discussion with the quality manager, it is noted that medication competencies for some staff have expired. On review of two registered nurse staff files it is noted that medication competencies have not been conducted and syringe driver training and competency has expired. One rest home caregiver file evidenced medication competency last conducted in 2011.
Corrective Action: Ensure that medication competencies are conducted annually for all staff that have responsibilities for administering medications.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.5 (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: Ace Foods contractors have the food provision contract for Leslie Groves. A large purpose built kitchen is located on the ground floor. Ace Foods has policies/procedures for food services and menu planning appropriate for the services. Winter and summer menus are created by a registered dietitian. There is a kitchen manual, which contains policies and procedures related to cleaning equipment used in the kitchen and the kitchen itself, food handling, and preparation, personal hygiene in the kitchen, nutritional plan, quality aims, checking of temperatures, food storage, kitchen access, and routines. A dietary assessment is made by the RN as part of the assessment process. There was evidence of residents receiving supplements. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers is covered and dated. ACE food services conduct audits as part of their own food safety programme. Special or modified diets are catered for. Advised that resident's food preferences are identified on admission. This includes consideration of any particular dietary needs (including cultural needs). Each resident has a dietary assessment that provides information on dietary needs and preferences. Each resident has a menu sheet that ensures the correct meals are delivered. Soft and puree dietary needs are documented. Leslie Grove conducts audits including: a) fridge and freezer temperature recordings; b) annual resident survey; Food and meals are agenda items at the resident meetings. The rest home, hospital unit, dementia unit and PG unit all have open planned dining and kitchenettes. Hot water is kept behind locked cupboards. Food is transported to each unit (including the rest home) via hot boxes. The rest home kitchen staff member receives the meal dishes and these are kept hot until serving. Staff record the temperature of hot and cold dishes prior to serving. Resident and families 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.

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

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

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

Attainment and Risk: FA
Evidence: Previous certification audit identified that not all chemicals were stored securely in the PG unit, cleaning trolleys were not stored securely when not in use. On a tour of the hospital and rest home facilities it was noted that all chemicals are appropriately labelled, stored securely in locked sluice rooms and cleaning trolleys are stored securely when not in use. Cleaning trolleys were not left unattended and staff have received training on safe chemical handling. The service has policy and procedures in place relating to chemical handling and storage. Within the newly refurbished areas of the hospital unit, PG unit and dementia unit, there are locked storage areas for chemicals and cleaning equipment. The service has made improvements in this area.

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

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

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 1.4.2: 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 Leslie Grove rest home facility building warrant of fitness expires on 16 May 2014. Previous verification audit identified that a certificate for public use had not been issued for the hospital. The service has now completed the refurbishment and rebuild work of the Leslie Groves hospital site and a certificate for public use was obtained. A new building warrant of fitness has been issued and expires on 16 March 2015. The new building warrant of fitness includes all new aspects of the build including fire alarms, sprinklers, lift and emergency lighting.

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.)*

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

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

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

Attainment and Risk: PA Moderate
Evidence: Previous certification audit finding identified that staff do not hold current first aid certificates. At the previous verification audit, it was identified that the hospital did not hold an approved fire evacuation scheme and that the call bell system in the PG unit was not fully functional. Fire drills are conducted six monthly – last held December

2013 for hospital site staff and December 2013 for rest home staff. The rest home fire evacuation scheme was approved in June 1995 and the hospital site fire evacuation scheme was approved on 5 February 2014. The call bell system within the rebuilt hospital, PG unit and dementia units are now fully functioning. The service addressed these areas that required improvement.
Leslie Grove provided an in-service (conducted by the quality manager) on first aid in October 2012 (attended by 31 staff) and first aid and emergency management in August 2013. The quality manager is not a certified first aid trainer. There is no training provided in CPR and there is not a staff member on 24/7 with a current first aid certificate. This is an improvement that continues to be required since previous certification audit.

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

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

Attainment and Risk: PA Moderate
Evidence: Previous certification audit finding identified that staff do not hold current first aid certificates. Leslie Grove provided an in-service (conducted by the quality manager) on first aid in October 2012 (attended by 31 staff from across hospital and rest home sites) and first aid and emergency management training was provided in August 2013. However, the quality manager is not a certified first aid trainer. There is no training provided in CPR.
Finding: First aid training is not provided by a certified trainer. CPR training is not provided for staff.
Corrective Action: Provide evidence that staff complete a certified first aid course and CPR course to ensure that there is at least one staff member on each shift on each site with a current first aid certificate.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Where required by legislation there is an approved evacuation plan.

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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when 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.)*

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:	PA Low
Evidence:	
There are policies around restraint, enablers and the management of challenging behaviours, which meet requirements of HDSS 2008. There are 12 hospital residents assessed as requiring enablers in the form of bedrails and one rest home resident and these are used as falls prevention and safety measures only. There are no residents using restraint. Policy dictates that enablers should be voluntary and the least restrictive option possible. The staff interviewed are familiar with this.	

Restraint/enabler use is discussed at management meetings, and at staff meetings. Restraint use audit conducted May 2013. Three monthly reviews of all enablers is conducted.
Staff received training around restraint minimisation and safe practice in February 2012. Management of challenging behaviours education was provided in April and October 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. Previous certification audit identified that a consent form for one enabler was not completed. On review of four resident files with enablers, it was noted that all consents were completed appropriately. The service has made improvements in this area. On review of one rest home resident, it is noted that staff are not documenting the monitoring of the bed rails when they are in place. Improvements are required in this area

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: PA Low
Evidence: Previous certification audit identified that a consent form for one enabler was not completed. On review of four resident files with enablers, it was noted that all consents were completed appropriately. The service has made improvements in this area. On review of one rest home resident, it is noted that staff are not documenting the monitoring of the bed rails when they are in place. Monitoring of enablers is recorded in progress notes in the three hospital resident files reviewed. The one rest home resident with an enabler does not have records for monitoring when in use.
Finding: Monitoring of an enabler in the rest home is not recorded.
Corrective Action: Ensure all documentation and records are completed for enabler use.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: Infection surveillance and monitoring is an integral part of Leslie Groves 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 management meetings, monthly staff meetings, monthly health, and safety/infection control meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the principal nurse manager. The quality manager (RN) is the designated infection control nurse and has attended infection control training in 2013.

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.)*