

# CHT Healthcare Trust - St Christophers

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Current Status: 26 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

St Christopher's Hospital and Rest Home provides residential care for up to 46 residents at rest home and hospital level care. There were 44 residents on the day of the audit - 12 at rest home level care and 32 at hospital level care. The facility is operated by CHT, the CHT group has strong board and effective governance practices. The current manager is a registered nurse who held management roles with CHT before commencing her current role in December 2010. She is supported by a clinical coordinator who is a registered nurse and has been in the role since 2009 and the area manager who is also a registered nurse. Resident and family feedback during the audit was very positive. A well-developed staff education programme is implemented with compulsory external (ACE programme) enrolment for new staff training.

All of the four shortfalls identified in the previous audit have been addressed. These were around incident form documentation, wound documentation, care plan evaluations and aspects of medication management.

This audit has identified one further area for improvement around medication administration.

## Audit Summary as at 26 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 |
|           | 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         |

| Indicator | Description  | Definition  |
|-----------|--|---|
|           | A number of shortfalls that require specific action to address                               | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|           | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk   |

### Consumer Rights as at 26 March 2014

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

### Organisational Management as at 26 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. |  | Standards applicable to this service fully attained. |
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### Continuum of Service Delivery as at 26 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 26 March 2014

|  |  |  |
|--|--|--|
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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### Restraint Minimisation and Safe Practice as at 26 March 2014

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

## Infection Prevention and Control as at 26 March 2014

|  |  |   |
|--|--|---|
| <p>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.</p> |  | <p>Standards applicable to this service fully attained.</p> |
|--|--|---|

# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

|   |  |                                |    |
|---|--|--------------------------------|----|
| <b>Legal entity name:</b>   | CHT Healthcare Trust   |                                |    |
| <b>Certificate name:</b>  | CHT Healthcare Trust - St Christophers   |                                |    |
| <b>Designated Auditing Agency:</b>  | Health and Disability Auditing New Zealand Limited   |                                |    |
| <b>Types of audit:</b>  | Surveillance Audit   |                                |    |
| <b>Premises audited:</b>  | St Christophers Rest Home & Hospital   |                                |    |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |                                |    |
| <b>Dates of audit:</b>  | <b>Start date:</b> 26 March 2014   | <b>End date:</b> 26 March 2014 |    |
| <b>Proposed changes to current services (if any):</b>   |  |                                |    |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> |  |                                | 44 |

## Audit Team

|                          |       |                            |   |                             |   |
|--------------------------|-------|----------------------------|---|-----------------------------|---|
| <b>Lead Auditor</b>      | XXXXX | <b>Hours on site</b>       | 8 | <b>Hours off site</b>       | 4 |
| <b>Other Auditors</b>    | XXXXX | <b>Total hours on site</b> | 8 | <b>Total hours off site</b> | 4 |
| <b>Technical Experts</b> |       | <b>Total hours on site</b> |   | <b>Total hours off site</b> |   |
| <b>Consumer Auditors</b> |       | <b>Total hours on site</b> |   | <b>Total hours off site</b> |   |
| <b>Peer Reviewer</b>     | XXXXX |                            |   | <b>Hours</b>                | 2 |

## Sample Totals

|  |    |                                   |    |                                      |    |
|--|----|-----------------------------------|----|--------------------------------------|----|
| Total audit hours on site                                      | 16 | Total audit hours off site        | 10 | Total audit hours                    | 26 |
| Number of residents interviewed                                | 7  | Number of staff interviewed       | 9  | Number of managers interviewed       | 3  |
| Number of residents' records reviewed                          | 5  | Number of staff records reviewed  | 5  | Total number of managers (headcount) | 3  |
| Number of medication records reviewed                          | 10 | Total number of staff (headcount) | 33 | Number of relatives interviewed      | 5  |
| Number of residents' records reviewed using tracer methodology | 2  |                                   |    | Number of GPs interviewed            | 1  |

## Declaration

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

I confirm that:

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

Dated Tuesday, 29 April 2014

## Executive Summary of Audit

### General Overview

St Christopher's Hospital and Rest Home provides residential care for up to 46 residents at rest home and hospital level care. There were 44 residents on the day of the audit - 12 at rest home level care and 32 at hospital level care. The facility is operated by CHT, the CHT group has strong board and effective governance practices. The current manager is a registered nurse who held management roles with CHT before commencing her current role in December 2010. She is supported by a clinical coordinator who is a registered nurse and has been in the role since 2009 and the area manager who is also a registered nurse. Resident and family feedback during the audit was very positive. A well-developed staff education programme is implemented with compulsory external (ACE programme) enrolment for new staff training.

All of the four shortfalls identified in the previous audit have been addressed. These were around incident form documentation, wound documentation, care plan evaluations and aspects of medication management.

This audit has identified one further area for improvement around medication administration.

### Outcome 1.1: Consumer Rights

There is an open disclosure policy, which describes ways that information is provided to residents, and families/representatives at entry to the service continually and as required. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints.

### Outcome 1.2: Organisational Management

St Christopher's Hospital and Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Quality information is reported to the two monthly combined staff and quality meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly resident meetings, at resident's focus groups and via annual satisfaction surveys. The resident satisfaction survey shows resident satisfaction has improved from the 20th percentile across 177 similar facilities in Australasia to the 59th percentile in 2013. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. St Christopher's Hospital and Rest Home has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertake external training. The service has a documented rationale for determining staffing and health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

**Outcome 1.3: Continuum of Service Delivery**

Residents' care plans are individualised for each resident. Residents' clinical notes are integrated to ensure service delivery reflects continuity of care, including input from all providers involved. Residents are assessed within set timeframes and receive well-planned and co-ordinated services. There is an activities programme that operates formally over seven days, which offers a variety of activities suited to the needs of the residents. Medicine is administered via the robotic sachet dispensing system. Medicine reconciliation requires recording and a corrective action is made accordingly. Staff that dispense medicines have been assessed as competent. An improvement is required around medication administration. Residents' nutritional needs are assessed on admission and likes, dislikes and allergies are communicated to the kitchen staff at admission. The menu was reviewed by a dietitian.

**Outcome 1.4: Safe and Appropriate Environment**

The building is purpose built. Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. All bedrooms, bathrooms and communal areas have a call bell system. There is current building warrant of fitness.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently three residents requiring restraints and six residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

**Outcome 3: Infection Prevention and Control**

The infection control coordinator is a registered nurse. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of Attainment

|                  | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| <b>Standards</b> | 0  | 16 | 0             | 0      | 1           | 0       | 0           |
| <b>Criteria</b>  | 0  | 41 | 0             | 0      | 1           | 0       | 0           |

|                  | UA Negligible | UA Low | UA Moderate | UA High | UA Critical | Not Applicable | Pending | Not Audited |
|------------------|---------------|--------|-------------|---------|-------------|----------------|---------|-------------|
| <b>Standards</b> | 0             | 0      | 0           | 0       | 0           | 0              | 0       | 33          |
| <b>Criteria</b>  | 0             | 0      | 0           | 0       | 0           | 0              | 0       | 59          |

## Corrective Action Requests (CAR) Report

| Code         | Name                                 | Description   | Attainment  | Finding  | Corrective Action  | Timeframe (Days) |
|--------------|--------------------------------------|---|-------------|--|--|------------------|
| 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 | The healthcare assistant witnessed giving lunchtime medication did not check the medication being administered against the medication chart. | Ensure all medication is checked against the medication chart before administration. | 60               |

## Continuous Improvement (CI) Report

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

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

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## Outcome 1.1: Consumer Rights

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

### Standard 1.1.9: 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:**

Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eight incidents/accidents forms were viewed for March 2014. The forms includes a section to record family notification. All eight forms indicated family were informed or if family did not wish to be informed. On interview seven residents (five from the rest home and two from the hospital), five family members (three from the rest home and two from the hospital), six health care assistants (who work across all areas), one registered nurse and the clinical coordinator all stated that family are informed following changes in the residents' health status.

The registered nurse interviewed stated that they record contact with family/whanau. Contact records were documented in all files reviewed.

Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.

A residents meeting occurs six weekly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. In July 2013, the area manager met with families and residents to provide feedback following the resident and family survey.

There is a policy that describes the availability of interpreter services when required. The service has residents who speak both Hindi and Samoan as their first language and they attempt to roster both a Hindi speaking staff member and a Samoan-speaking staff member onto every morning and afternoon shift.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

D16.1b.ii: 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 agreement.

D16.4b: Five family members stated that they are always informed when their family members health status changes.

D11.3: The information pack is available in large print and advised that this can be read to residents.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with seven residents (five from the rest home and two from the hospital), inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints

There is a complaints register but this does not include all complaints and this is an area requiring improvement. It is noted that the complaints register was updated to include all complaints during the audit. Complaints for 2013 and 2014 to date were reviewed (there have been four complaints in 2014 to date). Verbal and written complaints are documented.

All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.

Discussions with seven residents and five family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with six health care assistants (who work across all areas), stated that concerns/complaints were discussed at monthly staff /quality meetings.

There have been no external complaints.

D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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

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

**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.

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

## Outcome 1.2: Organisational Management

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br><p>St Christopher's Hospital and Rest Home provides residential care for up to 46 residents at rest home and hospital level care. There were 44 residents on the day of the audit - 12 at rest home level care and 32 at hospital level care. St Christopher's is certified to provide medical services. At the time of the audit, there were no residents under this category of care.</p> <p>St Christopher's has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan for 2014. The quality process being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Combined staff /quality / health and safety / restraint discuss key components of the quality system and any issues are reported. There is a six monthly internal audit completed by the area manager and corrective action plans are used to manage shortfalls.</p> <p>The current manager is a registered nurse who was a clinical coordinator with CHT before commencing her current role in December 2010. She is supported by a clinical coordinator who is a registered nurse and has been in the role since 2009 and the area manager who is also a registered nurse.</p> |

The manager and the clinical coordinator share on-call. Job descriptions for the manager and the clinical coordinator outline their authority, accountability and responsibility. The manager and the clinical coordinator have completed on-going training appropriate to their positions. There is RN cover in the facility 24/7.

ARC, D17.3di (rest home), D17.4b (hospital): The manager and clinical coordinator have maintained at least eight hours annually of professional development activities related to managing a hospital and rest home.

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

St Christopher's has a quality framework that is being implemented. The manager is directly involved in operations at the facility and the clinical coordinator registered nurse (RN) supports her in this role. There is a current business plan that includes goals and a quality assurance plan, which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (six health care assistants (who work across all areas), one registered nurse and the clinical coordinator and manager); inform an understanding of the quality activities undertaken at St Christopher's.

Resident meetings occur three monthly (minutes viewed). Seven of seven residents interviewed are aware meetings are held. Annual surveys are conducted of residents and relatives. All residents and relatives interviewed stated they are asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service. The resident satisfaction survey shows resident satisfaction has improved from the 20th percentile across 72 similar facilities in Australasia to the 59th percentile in 2013.

Policies and procedures are in place with evidence of review. The manager and clinical coordinator manage quality systems. All staff are invited to attend the quality, health and safety meetings. The quality programme is reviewed annually and is being implemented. Information is reported through the two monthly staff /quality meetings. Meeting minutes include key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety.

Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. St Christopher's has three residents requiring restraints and six residents using enablers.

The area manager completes a comprehensive spot audit of the service six monthly. All issues found in the November 2013 spot audit have identified corrective action plans and resolutions.

Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to quality and staff meetings (when these occur). Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

St Christopher's has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be utilised. Six health care assistants interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA |
| <b>Evidence:</b>               |

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br>D19.3b; There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. All eight incident forms sighted (March 2014) are fully completed with dates and the information aligns with progress notes. This is an improvement since the previous audit. The incidents forms are then reviewed and investigated by the manager or clinical manager who monitor issues. All eight incident forms sighted and have been signed by a registered nurse. If risks are identified these are also processed as hazards. Incidents are collated monthly and reported to the quality, health and safety meetings.<br>Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards. |

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificates of RN's are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in five of five files reviewed.

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with six health care assistants described the orientation programme that includes a period of supervision. The health care assistants reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview and six health care assistants inform there is access to sufficient training. Medication competencies are completed for all staff who administer medication. These are checked by the clinical coordinator.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication.

## 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.

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA |
| <b>Evidence:</b>               |

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br><p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Health care assistants reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the manager and the clinical coordinator will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The clinical coordinator covers the managers during absences and holidays. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents.</p> |

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

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

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

## Outcome 1.3: 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:

Discussions with one registered nurse confirmed attendance at regular DHB education sessions.

Assessment, planning, evaluation, review and exit are undertaken by the registered nurses with input from allied health professionals and health care assistants as sighted in five resident files sampled (two from the rest home and three from the hospital).

Service delivery is primarily undertaken by health care assistants under the guidance of the registered nurses as evidenced in resident progress notes. Health care assistants have had comprehensive in-service education and enrolment in the ACE programme is mandatory. All have annual performance appraisals to ensure they are competent to provide care as required.

Residents have access to a GP and the manager has checked that the GP used has a current practising certificate. Residents are able to access their own GP providing the requirements of the service are met. The six health care assistants (who work across all areas), one registered nurse and the clinical coordinator interviewed expressed confidence in their own ability and that of their colleagues to provide a competent service and the seven residents interviewed and five family/whanau members interviewed expressed confidence in the skills of staff.

D16.2, 3, 4: Five files were reviewed (two from the rest home and three from the hospital), five of five files identified that an assessment and initial care plan were completed within 24 hours and a long term care plan completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes.

D16.5e; All five resident files (two from the rest home and three from the hospital) sampled identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly where this is the case.

An admission checklist is completed. The organisation clearly identifies and communicates the level of detail within policies, to meet current accepted good practice and meet legislative requirements. Residents are assessed initially for a) risk of falls, b) risk of pressure areas, c) continence, d) pain (where appropriate), e) Cornwell depression scale, f) nutrition. Reviews had occurred within the six-month period in five of five files sampled. Ten of the 10 resident medicine records sampled show that the medicines have been reviewed three monthly (link 1.3.12.1).

Doctors' visits and allied health notes (physiotherapist, dietitian, podiatrist etc.) are included in resident files. Assessment/monitoring forms such as continence monitoring, risk of falls, risk of pressure areas and pain management are available also wound management and monitoring.

Six health care assistants (who works across all areas), one registered nurse and the clinical coordinator interviewed could describe 'hand over' which occurs at the change of each shift. The service has a variety of ways in which they ensure that the service is co-ordinated. Residents' progress notes are updated daily for hospital residents and at least weekly for rest home, residents and these are readily available for all staff and allied health professionals to see. Staff meetings provide further opportunities for service co-ordination.

The GP interviewed, who knows the service well expresses a high level of confidence in the service and reports that the registered nurses contact him by telephone or fax at appropriate times or for non-urgent issues write up in the review book and he checks this on his scheduled visit.

Files reviewed rest home include: resident on controlled drugs for pain management, one resident with challenging behaviour.

Files reviewed hospital include: resident with complex needs one resident with frequent falls and weight loss, one resident with diabetes on insulin.

Tracer Methodology rest home:

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

Tracer Methodology hospital:

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

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

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

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

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

St Christopher's provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents, this is evidenced through interviews with six healthcare assistants, five families/whanau, one registered nurse, the clinical coordinator, seven residents and management team.

Residents' long-term care plans are completed by the registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The six health care assistants, one registered nurse and the clinical coordinator interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Staff state that when something that is needed is not available, management provide this promptly. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, scales, hoists and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted.

All clinical staff have access to residents' care plans and progress notes. The seven residents interviewed and five family/whanau members interviewed report staff are respectful and that their privacy and individuality is maintained. The facility is a member of the CHT and has access to up-to-date information on current accepted good practice, clinical care protocols and procedures. The staff education schedule was sighted for 2013 and demonstrates that staff receive appropriate training. Staff were observed to be respectful in residents' care delivery on the days of the audit.

D18.3 and 4: Dressing supplies are available and a storeroom is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

There are currently six wounds at the facility. Four of these wounds are pressure areas. All of the six wounds including pressure areas have an assessment and wound plan and dates for next the next review documented. The previous shortfalls around timeframes, assessment and planning for wounds have been met. The registered nurse and clinical coordinator interviewed described the referral process and related form should they require assistance from a wound specialist.

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b> <p>The service employs an occupational therapist eight hours a week and two activities coordinators that provide activities across seven days a week. Weekly activities programmes are planned in consultation with the residents and there are programmes running daily. The occupational therapist and the two activity coordinators meet monthly to develop the activities programme. A weekly planner is produced which is displayed in the rest home dining room and the hospital lounge and a copy given to each resident. The activities provided are in keeping with the strengths, interests and needs identified in each resident/s activities plan and include group activities and 1:1 activities for residents who have needs, which cannot be met in a group setting. The seven residents (five from the rest home and two from the hospital) interviewed reported they enjoy the activities programme and are not coerced to join in. Five family/whanau members (two from the rest home, and three from the hospital) interviewed reported they are happy with the activities provided and state the programme is varied and interesting. There are regular community outings. Activities for each resident are recorded on individual activity registers. Lifestyle questionnaires are completed on admission and this is used to plan activities with residents in consultation with the resident when possible and their families/whanau. There is an activity section on the care plan where goals are recorded to meet the activity needs of the resident and the appropriate interventions. This plan includes information on all aspects of a resident's past lifestyle and interests and was sighted in each of the five resident care plans sampled. The activities section of the care plans are reviewed six monthly and this had occurred in each of the five resident files sampled. D16.5d Resident files reviewed identified that the individual activity plan (which is part of the care plan) is reviewed at care plan review.</p> |

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br><p>The previous audit identified that there are no documented nursing evaluations to indicate the degree of achievement or response to interventions. In the five resident files sampled (two rest homes and three hospital) all care plans contained an evaluation and documented the degree of achievement against the goals. The previous shortfalls have been addressed.</p> <p>D16.4a The care plan policy includes the evaluation requirements. Care plans are evaluated six monthly or more frequently when clinically indicated in the form of a new InterRAI assessment and new care plan. There is evidence of the resident/family/whanau involvement in the care plan review. Five of five files sampled showed examples where the care plan had been updated to reflect resident needs. Records of regular reviews with the GP have been maintained.</p> <p>D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.</p> <p>ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.</p> |

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

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

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

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

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

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

### Standard 1.3.12: 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:**

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. There are two medication rooms. One for the hospital and one for the rest home. The service has robotic sachets, which are delivered weekly. The clinical coordinator and registered nurse check the medication on arrival from the pharmacy every Tuesday. Any discrepancies are reported to the pharmacy. The pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. The locked medication trolley is stored in the treatment room in one wing and the office in the other wing and taken out during administration times.

D16.5.e.i.2; Medication are reviewed three monthly or as required by the G.P. This is evidenced in 10 of 10 medication files sampled. All medications used in the rest home are prescribed for individual residents.

Medicines are only prescribed by GPs and paid for by the service when medicine is subsidised by Pharmac and includes packaging charges. The service encourages GPs to prescribe medicines that are funded.

Weekly checks of the controlled drug register occur. Medication errors are reported and managed through the incident reporting process.

Staff competencies are completed. All those deemed competent have completed documented medication competencies. There is a sample list of signatures and the one registered nurse interviewed described their responsibilities about medication administration.

Medication training has been completed in March 2014.

The medications systems procedure includes a section "Where residents are responsible for their own medication". This states a) "Store the medicines, including controlled drugs, in the resident's room in a locked cupboard or drawer that is accessible to the resident and staff and b) medicines should be checked every week. Appropriate senior staff and the doctor must assess a resident's ability to take their own medicine at least every three months using SM172.Frm Self-Medication Checklist. Alerts are to be entered for all residents who are self-medicating. These alerts will be printed on the duty report. Currently there are no residents self-medicating.

All documents and signing sheets are completed in ink and legible.

The previous audit identified regular non-packaged medication not been signed as administered and evidence of transcribing. In 10 of ten medication charts, reviewed, all non-packaged medications have been signed for and there was no evidence of transcribing. The shortfalls from the previous audit have been addressed. The healthcare assistant witnessed giving lunchtime medication did not check the medication being administered against the medication chart. This is an area requiring improvement.

**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:**

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. The service has robotic sachets, which are delivered weekly. Medication reconciliation is completed by the clinical coordinator and registered nurse.

Medication is reviewed three monthly or as required by the G.P for 10 of 10 medication charts sampled. Medicines are only prescribed by GPs or nurse practitioner and paid for by the service when medicine is subsidised by Pharmac and includes packaging charges. The service encourages GPs to prescribe medicines that are funded.

Medication errors are reported and managed through the incident reporting process.

The pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal.

**Finding:**

The healthcare assistant witnessed giving lunchtime medication did not check the medication being administered against the medication chart.

**Corrective Action:**

Ensure all medication is checked against the medication chart before administration.

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

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

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

**Attainment and Risk:** 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 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

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

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

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

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

### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

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

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

**Attainment and Risk:** FA

**Evidence:**

The CHT food service procedure provides information to staff about the food service procedure. Food services are contracted out and cooked on site by Medirest services. There is a summer and winter menu approved by the Medirest dietitian. Policies on food service are developed and implemented. These policies and practices meet the requirements of the food hygiene regulations act 1974. Four-week menus for summer and winter are appropriate and varied.

D19.2: Medirest employs two cooks and two catering assistants all of who have completed the Medirest food safety programmes. Special diets are available and catered for as are resident preferences.

A mini nutritional assessment is completed on admission for each resident and a copy given to the kitchen for their information. This is reviewed six monthly. Nutritional needs for each resident are entered on the care plan. The dietary preferences of each resident are displayed on a whiteboard in the kitchen.

The contracted food services dietitian makes changes to the menu.

Meals supplied include as routine, breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times, staff will provide a nutritious snack or drink if residents are hungry or thirsty. Extra snacks are provided when needed. Residents' weight is recorded on admission and monthly thereafter and was stable in four out of five resident files sampled. The other resident was on Replenish Energy and Protein (REAP) level three. After a weight loss of five percent over three months she was reassessed by a dietitian, and commenced on level four of the REAP programme.

The food service procedure states "Residents upon admission will have their individual preferences (likes/dislikes), religious and/or cultural requirements assessed by the care staff using the Dietary Information form. This assessment may include input from the family/ next of kin where appropriate.

There are copies of residents food preferences/ dietary needs in the kitchen and the cook was able to identify which residents required special meals (such as diabetic and those on the REAP programme).

There is a comprehensive quality assurance programme implemented in the kitchen. The following is included monthly; a) food safety audit, b) food temperature monitoring, c) fridge, freezer and dishwasher temperatures daily, and d) incoming food temperatures. Medirest operates a 'balanced score card' monitoring process to ensure compliance with the quality processes. The kitchen is clean and well maintained. The main grocery shop occurs weekly according to the menu. Food is stored in the pantry, the fridge and the freezer and temperatures are recorded daily. Food sighted in the fridge, freezer and pantry was covered and dated and raw food was stored below cooked food. Different coloured chopping boards are used for different food types and there is a roster for kitchen cleaning. The kitchen was clean on the day of the audit. The seven residents (five from the rest home and two from the hospital) interviewed and five family/whanau (two from the rest home and three from the hospital) interviewed state they are happy with meals provided.

The service is using a Replenish Energy and Protein (REAP) programme. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and caregiver meetings. The documented programme has been developed by the Medirest dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. There are three levels. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. Those residents on the programme are clearly documented on the whiteboard in the kitchen. When a resident is identified as having, unintended weight loss a weight loss report is completed. This includes checking the mouth and teeth, reviewing diet type, monitoring

food intake, consulting with the cook, consulting the dietitian, referring to the GP, referring to family and reviewing medication. One file was sampled for a resident who have been on REAP level three and after a weight loss commenced on level four. The cook was aware and documentation sighted. The six health care assistants (across all areas), one registered nurse and the clinical coordinator interviewed are all familiar with REAP and report the benefits to residents. The Medirest area manager interviewed reports that ways in which they implement REAP include fortifying food wherever possible for those on the programme. Examples for REAP four include cream and brown sugar on cereals, extra margarine on vegetables, fortifying mashed potato, sauces and purees, cream on desserts in the evening, fortifying soup, providing fortified milk and fortified drinks and fortified custard for supper. The service continues to evaluate and improve the REAP programme and initial results show a marked decrease in weight loss for those using the programme.

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

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

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

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| <b>Attainment and Risk:</b> FA  |
| <b>Evidence:</b><br>There is a current BWOFF that expires on 16 March 2015. The home is warm and well ventilated. All electrical equipment is checked and tagged bi annually this is current. This last occurred in January 2014.<br>Staff report minor repairs and maintenance in a maintenance book kept at the nurses' station.<br>Records indicate all maintenance and repairs are addressed in a timely manner.<br>Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. There is a maintenance manager who oversees the facility. The manager states that when an issue requiring maintenance is noticed the staff document this on the maintenance sheet. These are checked every day and in most cases, the issue can be repaired or resolved on the same day. Otherwise, the issue is assessed and an action plan developed on the same day. External |

contractors are engaged to complete work as required. Equipment is calibrated and serviced annually and this last occurred in October 2013. There is sufficient space so that residents are able to move around the facility freely. The hallways are wide enough with handrails appropriately placed. All resident rooms are large enough to accommodate bed, chairs and lifting equipment. All rooms in all wings have en-suite shower and toilet. Flooring is appropriate, carpet in corridors and rooms vinyl in utility areas, and easily cleaned. The outside areas are easily accessed to decking with appropriate safety barriers. Hallways throughout the facility allow residents to pass each other when using walking aids such as walkers. There is non-slip lino in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. There are handgrips in bathroom and toilet areas. Residents were observed on the day of the audit, to independently and safely move around the inside and outside of the facility; other residents were observed to be assisted by staff. The seven residents (five from the rest home and two from the hospital) interviewed and five family members (three from the rest home and two from the hospital) interviewed confirm the physical internal and external environment of the facility is appropriate to the residents' needs. There is an outside area, which is well maintained and safe. Residents were observed to be moving around in external areas with and without mobility, frames and eight of eight residents interviewed reported that the outdoor areas are well enjoyed. ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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| <b>Attainment and Risk:</b> FA |
| <b>Evidence:</b>               |

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| <b>Attainment and Risk:</b> FA  |
| <b>Evidence:</b><br>The previous audit identified that hot water temperatures were too high. Hot water temperatures are checked monthly and records for 2014 show these are always below 45 degrees Celsius. The previous shortfall has been addressed. |

**Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br><p>There is a restraint policy There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.</p> |

The restraint manual determines that enablers are voluntary and the least restrictive option. There are three residents requiring restraints and six residents using enablers. Two enabler files were reviewed and included consents and assessments.

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

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

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

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

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

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

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| <b>Attainment and Risk:</b> FA   |
| <b>Evidence:</b><br>Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at St Christopher's are appropriate to the acuity, risk and needs of the residents.<br>The infection control coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff, / quality meeting and the monthly RN meeting. The infection control coordinator uses the information obtained through the surveillance of |

data to determine infection control education needs within the facility.

Internal audit of infection control is included in the annual programme and occurs monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

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

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

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

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

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

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

