

Leighton House Limited

Current Status: 20 May 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification 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

Leighton House provides rest home and hospital level care for up to 50 residents.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings.

An operations manager and a clinical manager manage Leighton House on a daily basis. The operations manager reports directly to the general manager and the clinical manager reports directly to the regional clinical manager North Island. There have been a number of improvements made to the environment since the last audit.

There are improvements required by the service around the incident reporting, registered nurse follow up and care plan interventions.

Audit Summary as at 20 May 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	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 20 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 20 May 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 20 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 20 May 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 20 May 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 20 May 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 20 May 2014

Consumer Rights

Leighton House strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained.

Organisational Management

Dementia Care NZ Ltd is the parent company of Leighton House. The operations manager of Leighton House reports to the general manager on a monthly basis against the quality and risk management plan and also the vision and values. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and other staff meetings. Corrective actions are identified and implemented and show follow up and review. Health and safety policies, systems and processes are implemented to manage risk. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held.

There are comprehensive policies/procedures to provide hospital and rest home level care. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of Service Delivery

The service information provided to all residents and family includes all aspects of service provision.

The assessments and initial care plan are completed by registered nurses (RNs). Since the change of owner in 2013, all resident files include a new initial assessment, updated assessments and long term care plan (LTCP). Care plans document six monthly reviews as needed with updates as required. Assessments and activities care plans were completed by the diversional therapist in all seven files reviewed. Families are involved in the development and review of the care plan. A multi-disciplinary meeting occurs six monthly.

Improvements are required around care plan intervention documentation and registered nurse follow-up of problems identified through progress notes.

There is a planned monthly and weekly activities programme that is developed by recreation staff the individual activity plans are comprehensive and documented very well.

There is at least a three monthly review by the medical practitioner of the resident and their medications.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management.

The main kitchen cooks all meals on site. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files.

Safe and Appropriate Environment

The building holds a current warrant of fitness. There are a number of decks around the outside of the building. The decks are either covered by a veranda or enclosed as a conservatory. There are a number of lawns and well-kept gardens.

This audit identified that the North wing is appropriate for dual use beds (swing beds hospital and rest home). There are adequate toilets and showers. A number of resident rooms include single ensuites and others include shared ensuites. A small number of rooms share common facilities. Fixtures, fittings and floorings are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are done on site and are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are available. There is an approved evacuation scheme and emergency food supplies are held on site and a large supply of water. The facility has is well laid out and the temperature is comfortable and constant. Residents and family interviewed are very satisfied with the environment.

Restraint Minimisation and Safe Practice

The service is currently enabler and restraint-free. There is a comprehensive assessment process documented which includes relevant forms. The service is required to review the entire care plan monthly if a resident has restraint and this was documented well in the one (previous) restraint file reviewed.

The assessment/approval and evaluation process is undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The service also completes post-restraint surveys.

Restraint competencies/ training and challenging behaviour training has been provided to staff.

Infection Prevention and Control

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked with other facilities within the organisation. The results are used to identify any shortfalls in care services and infection control.

HealthCERT Aged Residential Care Audit Report (version 3.92)

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:	Leighton House Limited
Certificate name:	Leighton House Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
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Types of audit:	Certification Audit
Premises audited:	Leighton House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 May 2014 End date: 21 May 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:	44
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Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	14	Total audit hours	38
Number of residents interviewed	8	Number of staff interviewed	12	Number of managers interviewed	4
Number of residents' records reviewed	7	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	35	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA 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	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Monday, 16 June 2014

Executive Summary of Audit

General Overview

Leighton House provides rest home and hospital level care for up to 50 residents. On the day of audit, there were 44 residents including three hospital residents and 41 rest home residents.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings.

An operations manager and a clinical manager manage Leighton House on a daily basis. The operations manager reports directly to the general manager and the clinical manager reports directly to the regional clinical manager North Island. There have been a number of improvements made to the environment since change of owner June 2014.

There are improvements required by the service around the incident reporting, registered nurse follow up and care plan interventions.

Outcome 1.1: Consumer Rights

Leighton House strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained.

Outcome 1.2: Organisational Management

Dementia Care NZ Ltd is the parent company of Leighton House. The operations manager of Leighton House reports to the general on a monthly basis against the quality and risk management plan and also the vision and values which are embedded into practice. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and other staff meetings. Corrective actions are identified and implemented and show follow up and review. Health and safety policies, systems and processes are implemented to manage risk. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held.

There are comprehensive policies/procedures to provide hospital and rest home level care. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Outcome 1.3: Continuum of Service Delivery

The service information provided to all residents and family includes all aspects of service provision.

The assessments and initial care plan are completed by RNs. Since the change of owner in 2013, all resident files include a new initial assessment, updated assessments and long term care plan (LTCP). Care plans document six monthly reviews as needed with updates as required. Assessments and activities care plans were completed by the diversional therapist in all seven files reviewed. Families are involved in the development and review of the care plan. A multi-disciplinary meeting occurs six monthly.

Improvements are required around care plan intervention documentation and registered nurse follow-up of problems identified through progress notes.

There is a planned monthly and weekly activities programme that is developed by recreation staff the individual activity plans are comprehensive and documented very well.

There is at least a three monthly review by the medical practitioner of the resident and their medications.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management.

The main kitchen cooks all meals on site. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files.

Outcome 1.4: Safe and Appropriate Environment

The building holds a current warrant of fitness. There are a number of decks around the outside of the building. The decks are either covered by a veranda or enclosed as a conservatory. There are a number of lawns and well-kept gardens.

This audit identified that the North wing is appropriate for dual use beds (swing beds hospital and rest home). There are adequate toilets and showers. A number of resident rooms include single ensuites and others include shared ensuites. A small number of rooms share common facilities. Fixtures, fittings and floorings are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are done on site and are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is available. There is an approved evacuation scheme and emergency food supplies are held on site and a large supply of water. The facility has is well laid out and the temperature is comfortable and constant. Residents and family interviewed are very satisfied with the environment.

Outcome 2: Restraint Minimisation and Safe Practice

The service is currently enabler and restraint-free. There is a comprehensive assessment process documented which includes relevant forms. The service is required to review the entire care plan monthly if a resident has restraint and this was documented well in the one (previous) restraint file reviewed.

The assessment/approval and evaluation process is undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The service also completes post-restraint surveys.

Restraint competencies/ training and challenging behaviour training has been provided to staff.

Outcome 3: Infection Prevention and Control

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked with other facilities within the organisation. The results are used to identify any shortfalls in care services and infection control.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	42	0	3	0	0	0
Criteria	0	90	0	3	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	5	0	0
Criteria	0	0	0	0	0	8	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	(i) Incident form didn't identify neuro obs. Completed when the resident had a head injury; (ii) one resident file identified a sacral pressure injury, no incident form was completed; (iii) one incident form reviewed did not identify the incident in the progress notes.	(i) Ensure neuro obs are documented where the resident has a head injury; (ii) Ensure incident forms are completed for pressure injuries; (iii) Ensure incidents and follow up/assessment are also completed in the progress notes.	60
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	Of the seven resident files reviewed; one resident file identified the resident had had a xxx xxxx for which there was documented RN follow up. One resident has a xxxxx for which there was no documented follow up. Three residents with identified pain did have their pain reviewed though progress notes but no formal pain assessment form or process.	Ensure that problems and issues identified in progress notes always have documented registered nurse review and follow up care.	30
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	(i)Of the seven resident files reviewed it was noted that care plan interventions were often documented in the evaluations section of the care plan (rather than the care interventions section). (ii) One hospital level resident with a xxxxx, one with a reddened sacral area and a one resident with a heat rash did not have interventions documented on a STCP or the LTCP updated.	Ensure care plan interventions are documented in the intervention section of the LTCP and (ii) Ensure interventions to manage short term medical issues are documented on a STCP or the LTCP updated.	30

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 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

There is a code of rights policy and procedures in place. The code of health and disability rights is incorporated into care. Discussions with five caregivers (across the three shifts) identified their familiarity with the code of rights.
A review of care plans, meetings (including resident meeting) and discussion with two rest home family members confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided on the code of rights and advocacy November 13. Code of rights is also included in the orientation training session and a competency package is completed by staff.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

The service provides information to residents, families, next of kin and/or EPOA. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. On entry to the service, the clinical manager or operations manager discusses the information pack with the resident and their family/whānau. This includes the code of rights, complaints and advocacy information. Discussions with two family members identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. Resident/family right to access advocacy and services is identified and advocacy service leaflets are available at the entrance. The information identifies who the family can contact to access advocacy services. Information provided prior to entry provides them and their family/whānau with advocacy information. This includes details of the national and local advocacy services. There is an identified advocate who visits residents regularly. Discussions with five caregivers identified they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention 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.)*

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

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

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

Attainment and Risk: FA

Evidence:

The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information.

Discussions with two family members identified that personal belongings are not used as communal property.

During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews with family members and residents identified that caregivers always respect residents' privacy. The 2014 resident survey identified 90% were happy with privacy being managed.

Resident files are held in locked nurses' cupboard at nurses' station.

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

There is an abuse and neglect policy that includes definitions and examples of abuse. Staff could describe definitions. Discussions with four registered nurses, clinical manager, and five caregivers identify that there is a strong culture of reporting. Relatives interviewed said that the care provided is very good. Abuse and neglect questionnaire has been completed by staff in orientation. Staff training was last delivered in May and November 2013.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

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

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p>

Corrective Action:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA

Evidence:

The service gathers appropriate spiritual, religious and cultural information that is relevant and sufficient to support an appropriate response to the needs of residents. There are two Maori residents in the rest home. Files reviewed included consideration to cultural needs. Planning is done in conjunction with the resident/family. The service's philosophy of care results in each person's cultural needs being considered individually. External specialist advice is sought as necessary.

There are current guidelines for the provision of culturally safe care for Māori residents. Discussions with four registered nurses, clinical manager, operations manager and five caregivers indicate that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori. Individual cultural values are identified and documented through the assessment and admission processes and staff make every effort to assist residents to practice their cultural values. Special events and occasions are celebrated at Avonlea.

Family/whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to attend residents' reviews. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

D20.1i The service has established a local contact who is Māori and is available for advice as required.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

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 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported 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.)*

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

The service establishes links with family/whanau or other appropriate representatives as required. Family meetings occur at admission, and at multi-disciplinary team meetings. The operations manager, clinical manager or registered nurse contacts family when required. Four rest home relatives interviewed confirmed they are consulted regarding individual values and beliefs. Six rest home residents and two hospital residents confirmed their culture and values are considered.

The 2014 resident's survey and relatives survey identified 90% and 82% respectively confirmed values/beliefs and culture were addressed.

D3.1g The service provides a culturally safe service by implementing the organisation's vision and values of care and service which promotes the uniqueness of the individual and provides opportunities to enrich the lives of each resident.

During the admission process, the registered nurse along with the family/whanau complete the documentation. The assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. Initial and on-going assessment includes gaining details of people's culture, beliefs and values. D4.1c There is a section around expressing spirituality and culture in the care plan.

Families are actively encouraged to be involved in their relative's care in whatever way they want.

The organisation provides an Intercultural Awareness education programme for staff that was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector. Cultural safety is part of the orientation training and competency package

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

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 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

There is an abuse and neglect policy, residents' code of rights policy, complaints policy and process, staff code of conduct which includes discrimination and professional boundaries. Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Qualified staff are, in addition, required to abide by a professional code of ethics. The code of conduct discusses consequences if the code of conduct is not followed. Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Discussion with the operations manager and a review of complaints identified no complaints of discrimination, coercion or exploitation of residents. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with six rest home residents and two hospital residents identify that privacy is ensured. Discussions with five caregivers described how professional boundaries are maintained

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being 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.)*

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

A2.2 Services are provided at Leighton House that adhere to the health and disability services standards. There is an implemented quality improvement programme that includes performance monitoring. There are well developed manuals for all areas of the service and include management, human resource, clinical, health and safety, kitchen, laundry and activities. Policies and procedures and associated implementation systems are in place 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.

A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. There is an internal audit schedule. It includes (but is not limited to): clinical compliancy, complaints management, environmental safety, health and safety, infection control, kitchen/food, household services, medications, quality and risk management, resident's admission, resident care, restraint minimisation, staff education, incidents and accidents, and asset and maintenance review.

Benchmarking with QPS also occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2014. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint.

Resident and relative surveys are completed annually. Other surveys include six week post admission survey, restraint response survey and respite survey. A review of the four respite surveys received YTD identified all spoke positively about their experience.

Four rest home family members interviewed spoke very positively about the care provided and were well informed and supported.

Six rest home residents and two hospital residents spoke positively about the care and the changes made since change of owner.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

The following improvements have been made to the service since change of owner in June 2013.

1. Painting and carpeting of whole facility
2. Installation of kitchenettes in two lounges
3. Change over to DCNZ Quality System.
4. Participation in DCNZ Organisational IC, H&S and Restraint meetings occur six monthly and we have representatives from Leighton House at each meeting.
5. Hazard Register is now reviewed three monthly.
6. Implementation of an incident management database.
7. Implementation of a Complaints, Staff Accident and Quality Improvement Database
8. Implementation of Internal Benchmarking for both levels of care.

9. Infection control surveillance system
10. Inter cultural Awareness programme for staff
11. Diversional therapy team are supported by an Organisational Diversional Therapy Coordinator who is available to all facilities.
12. Provision of supervision training and supervision of all RNs
13. Transition of East Wing into a hospital level wing.
14. Best Friends Approach to Care education programme for staff
15. Staff support provided by Vitae Services

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Four family members stated they and the resident were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur monthly.

The clinical manager and the operations manager have an open-door policy.

Incident forms have a section to indicate if family have been informed (or not) of an incident/accident. Fifteen incident/accident forms were reviewed for May 2014. In all 15 forms reviewed, contact with families after an incident/accident is documented on the incident forms and in the progress notes.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term

residential care in a rest home or hospital – what you need to know” is provided to residents on entry.

D16.1b.ii Residents/family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

D16.4b Four family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

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

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whānau have difficulty with written or spoken English that the interpreter services are made available.

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: FA

Evidence:

Policy for informed consent and resuscitation are in place and available to staff. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights.

Required consent forms and advance directive forms were evident on seven resident files reviewed (four rest home and three hospital).

Consent forms include photo, medical records and outings.

Discussions with five caregivers, who work across both hospital and rest home, confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with four registered nurses identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

Completed advance directives forms were evident on all seven resident files reviewed (four from the rest home and three from the hospital).

D13.1 Six resident agreements were viewed for residents admitted since the new provider started. All were in place and had been signed.

D3.1.d Discussion with four rest home family identified that the service actively involves them in decisions that affect their relative's lives.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained 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 1.1.10.7 (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: 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 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA

Evidence:

The right to access advocacy services is identified for residents/families. There is an advocacy and consumer support policy in place. Leaflets are available at the entrance. The information identifies who to contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. An independent advocate visits monthly.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. There is a local advocate that comes and visits residents. D4.1d; Discussion with four family members identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

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 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

D3.1h; Discussion with four family members confirmed that they are encouraged to be involved with the service and care of the residents.

Visiting is actively encouraged. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interviews with activity staff and caregivers described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping.

Entertainers are included in the activities programme. The activities coordinators described how outings in the van are tailored to meet the interests of the residents. Residents are encouraged to maintain outside interests as appropriate. Assistance with transport is provided as required.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when 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 1.1.13: 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 in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available at the entrance and information is provided to residents and relatives at entry.

There is an established and up to date complaints register that is also included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Specific QIs are raised from complaints. For 2014 (to date) there has been five written complaints and one verbal complaint. The complaints were well documented and managed.

D13.3h. a complaints procedure is provided to residents within the information pack at entry. Following recent six week surveys analysis the service has sent out the complaints procedure and COR to relatives.

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:

Dementia Care NZ Limited (DCNZ) is the parent company under which Leighton House has been run since July 2013. Leighton House provides rest home and hospital – geriatric/medical care across the 20 bed hospital and 30 bed rest home. On the day of audit, there were three hospital residents and 41 rest home residents. There are no residents under the medical component of their certificate.

DCNZ operate a number of aged care facilities throughout NZ providing rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes the two directors, a general manager, a quality systems manager, a human resources strategy and organisation support manager, a vision development coordinator, an education coordinator, a diversional therapist coordinator, a business project manager, and a regional clinical manager North Island and a regional clinical manager South Island. They are supported by a number of corporate administration staff.

There is business plan in place for all facilities covering the period July 2013 to June 2014. The plan includes the vision and values of the organisation, strategic goals, market analysis and future directions. The vision of DCNZ is “to create a loving warm and homely atmosphere, where each person is supported to experience each moment richly.” The values are “we strive to achieve this vision by promoting the uniqueness of each person, the immense value of each person, openness honesty and integrity; in these ways we enrich each person, the community and the world.”

An operations manager and a clinical manager manage Leighton House on a daily basis. The operations manager reports directly to the general manager and the clinical manager reports directly to the regional clinical manager North Island. The operations manager was appointed to the position in August 2013. Prior to her appointment, she was employed as a full time caregiver at Leighton House. She has worked in the facility for 15 years. Her qualifications include a national certificate in aged care. She is directly responsible to the Directors. Her job description includes the primary objectives of the role, her key tasks, performance indicators, and performance measures. The operations manager reports daily to the general manager and there is a set process of monthly reporting in place. She completed a 10 days orientation with an Operations Manager from another DCNZ site two days training with Quality System Manager on the DCNZ quality system and monthly operational reviews with the DCNZ Quality Systems Manager. Manager’s training programme for all DCNZ managers, is planned for mid-2014.

The operations manager is supported by a clinical manager (CM). The CM is new to the role (3 weeks). She has been working at other DCNZ sites as a registered nurse and relieving clinical manager. She has attended at least eight hours annually in regards to her role and is supported by a regional clinical manager North Island.

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.

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

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.

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

During a temporary absence of the operations manager, the clinical nurse manager assumes the role. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. There are relevant care and support policies including relevant clinical procedures for the management of hospital and rest home level residents. At Leighton House there is a number of GPs, Physiotherapist (visits weekly) and a dietitian (visits monthly). There is also an organisational Diversional Therapy Coordinator. At an organisational level there is a North Island Clinical Manager that provides clinical support and leadership. Allied health professionals are accessed on an as required basis.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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:

Leighton House has a strategic business plan and a quality and risk management plan that are implemented and managed at service level by the quality team. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly quality meetings, weekly planning meetings with home managers, monthly registered nurse meetings, monthly health and safety meetings, monthly infection control meetings and monthly reports to the directors.

The quality committee meeting includes (but is not limited to): infection control, accidents/incidents, restraint, quality goals, quality activities, policies and procedures, health and safety, staff, family issues, complaints, marketing, education and clinical issues. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. Benchmarking is used as a means of identifying trends and potential risks or for advanced planning.

D5.4 The service has the following policies/ procedures to support service delivery. There is a document and data 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 collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and the clinical manager completes the follow up. All incident/accident forms are seen by the operations manager who completes any additional follow up and collates and analyses data to identify trends. Results are discussed with staff through the monthly meetings including: registered nurse, quality committee, health and safety, infection control and the operations manager's monthly report to the directors/proprietors. Complaints/concerns are recorded in a complaints folder. There is a spread sheet/data base register in place. There is evidence that complaints/concerns are followed up and any concerns raised through resident meetings, and surveys are followed up and actioned.

Infection control data is collated monthly and reported to the monthly infection control committee meeting, the quality committee meetings, and monthly staff bulletin. Actual and potential risks are identified and corrective actions initiated. This is discussed at the monthly quality meetings, monthly health and safety meetings and reported to the directors/proprietors in the operations manager's monthly report. There is a hazard identification register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually.

Restraint is reviewed at the monthly quality meetings and six monthly restraint approval committee.

Corrective actions are established as a result of internal audits, incidents, accidents, complaints and concerns. Examples include (but not limited to) include; documentation/reporting, BSL monitoring, protective equipment, calls bells, and foot plates on chairs. Corrective actions are discussed at staff meetings and quality meetings. Meeting minutes are documented using a corrective action format. Discussions with the clinical manager, and four registered nurses described how corrective actions are implemented. Internal audits are completed. Corrective actions identify the actions required, the person responsible, documentation of actions completed and signed completion. The QI log identified new quality initiatives.

D19.3 There are implemented risk management and health and safety policies and procedures in place including incident/accident and hazard management. The health and safety policies include (but are not limited to): hazard identification; hazard management; staff responsibilities; employee participation in health and safety systems. There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate.

The monthly health and safety meetings identify actual and potential risks and corrective actions are initiated. Monthly incident/accident data are collated and actual and potential risks are identified.

D19.2g fall prevention strategies are in place that include: assessment of risk, medication review, vitamin D, assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls

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.

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

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.

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

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p>

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.

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

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.

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

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: PA Low

Evidence:

D19.3d the service is aware that they will inform the DHB of any serious accidents or incidents. Discussions with the operations manager, and clinical nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.

Fourteen of fifteen incident forms reviewed for May identified they were fully completed and followed up appropriately by the RN. There is an improvement required to incident/accident documentation.

Minutes of the monthly quality and health and safety meetings, registered nurse, reflect a discussion of incidents/accidents and actions taken. Internal benchmarking includes an analysis. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level.

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: PA Low

Evidence:

The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required. Fourteen of 15 incident forms reviewed for May identified that they were fully completed and followed up appropriately by the RN.

Finding:

(i) Incident form didn't identify neurological observations (Neuro obs). Completed when the resident had a head injury; (ii) one resident file identified a sacral pressure injury, no incident form was completed; (iii) one incident form reviewed did not identify the incident in the progress notes.

Corrective Action:

(i) Ensure neuro obs are documented where the resident has a head injury; (ii) Ensure incident forms are completed for pressure injuries; (iii) Ensure incidents and follow up/assessment are also completed in the progress notes.

Timeframe (days): 60 *(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:

Leighton House employs a total of 35 staff. Staff orientation policy and procedures includes training and support packages for operations manager, clinical manager, registered nurses, caregivers, activities staff, and cook and kitchen staff. There are job descriptions available for all positions and staff have employment contracts.

Six staff files were reviewed (operations manager, registered nurse, two caregivers, diversional therapist, and clinical manager). Job descriptions were evident in all files reviewed.

Performance appraisals are up to date.

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 sighted for all registered nurses, and allied/medical staff.

There is a comprehensive human resources manual which includes policies around recruitment, selection, orientation and staff training and development. Reference checks are completed before employment is offered and are evident in the six staff files reviewed.

Orientation programme and packages for all roles. Five of six files reviewed showed evidence of orientation to roles with competency packages completed (the clinical manager is still in the process of completing the orientation).

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Five caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Competency packages for registered nurses include (but not limited to)-, restraint minimisation and safe practice, first aid, ACE dementia series, delirium, syringe driver, medication, neurological conditions and leadership. Caregivers competency package include (but not limited to), restraint minimisation and safe practice, first aid, taking vital signs, safe medication administration, ACE programme and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.

There is a spread sheet of all staff and records all completed orientations, competencies and education attended.

There is an in-service calendar completed for 2013 and currently being implemented for 2014. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Staffing Levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in place and show staff coverage across the facility. There is an RN based in the hospital unit 24/7 and a clinical manager five mornings a week. Operations Manager and Clinical Manager (RN) work Mon - Fri. Interviews with four relatives, four registered nurses and five caregivers confirmed that staffing levels are good across each area.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the office. Resident records are kept up to date and reflect residents' current overall health and care status. Records can be accessed appropriately by staff.

D7.1 Entries are legible, dated and signed by the relevant staff member including designation.

Individual resident files demonstrate service integration. Medication charts are in a separate folder.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

The service has a well-developed assessment process and resident's needs are assessed prior to entry. There are admission procedures and policy in place.

Information gathered at admission is retained in resident's records.

The service has a well presented information booklet for residents/families/whānau at entry "Introducing our home". It is comprehensive and designed so it can be read with ease (spaced and larger print).

The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights and advocacy information.

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks.

D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

D14.1: Exclusions from the service are included in the admission agreement.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

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 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau.
Staff report that they have not declined entry to services.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative 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 1.3.3: 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: PA Low

Evidence:

Leighton House provides rest home and hospital level care including medical. The service has three residents at hospital level including one at palliative care.

D16.2, 3, 4: All assessments on admission, including the initial care plan, are undertaken by RNs.

This audit included selected a review of three extra resident files to check timeliness of care plans for residents admitted since the new service provider commenced. The three files all identified that the initial assessment and support plan is completed within 24 hrs. Of admission and long term care plans written and implemented by the registered nurses within three

weeks.

The seven files reviewed (three hospital, four rest home) identified that all resident files have a new initial assessment, new assessments for continence, falls risk, pressure areas and nutrition. All files also have a new LTCP plan in place. All LTCP document that they have been reviewed six monthly with updates also documented on care plans. Assessments and activities care plans were completed by the diversional therapist in all seven files reviewed. The activity plans are comprehensive and documented very well.

D16.5e: GP assessments are documented within two days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. Each resident has retained their own GP with up to eight GPs visiting and providing services to residents within the service. A physio visits weekly and provides three monthly reviews and care as needed.

D17.1 (b) Copies of the registered nurses, GPs and other allied health providers practising certificates are copied and kept on file by the management team. There is a documented handover between shifts Staff who worked all shifts including four RNs, and five caregivers interviewed described a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes and hygiene care tick lists are completed every shift by caregivers, or more often if there are any changes. The four RNs interviewed stated that they write concerns/follow up assessments in the progress notes. Of the seven files, five documented that where issues have been identified in the resident progress notes, this was not always followed up by the RN and this is identified as an area for improvement. The process for pain assessments is identified as an area for improvement; The RNs have documented a pain review in two files reviewed, however this process is not formalised and three files did not document a pain assessment / review when pain was an identified problem. All seven resident files identify integration of allied health personnel including physio and podiatrist and a team approach is evident.

Relatives (four rest home) spoke highly of the all the staff, the care provided, activities programme, and the environment.

Tracer; Hospital level care.

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

Tracer; Rest home level care.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Seven care plans were reviewed for this audit. Care plans were all updated with associated assessments with this new provider. Overall the care plans are person centred and comprehensive.

Finding:

Of the seven resident files reviewed; one resident file identified the resident had xxxxxx xxxxxx for which there was documented RN follow up. One resident has a xxxxx for which there was no documented follow up. Three residents with identified pain did have their pain reviewed though progress notes but no formal pain assessment form or process.

Corrective Action:

Ensure that problems and issues identified in progress notes always have documented registered nurse review and follow up care.

Timeframe (days): 30 *(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: FA

Evidence:

The information gathered at admission is used to set care plan goals and objectives for residents. The admission health assessment form provides a comprehensive assessment on admission and is used to develop the care plan goals and objectives. There is an on-going assessment of resident's policy that includes assessments that should be in place and timeframes. RN's complete initial assessments within 24 hours of admission.

A range of assessment tools are completed on admission and reviewed at least six monthly as applicable and include (but not limited to); continence assessment, falls risk, Braden pressure area tool, wound, nutritional screening, activity initial assessment, and pain assessment tools (link 1.3.3.4). There are other allied health assessments completed such as dietitian assessment and physio assessment. The diversional therapist also completes a comprehensive social assessment. Assessments are conducted at the facility in agreement with the resident/family member or EPOA. Residents have private rooms where they can be assessed

Frequent falls physiotherapy assessments are carried out as required including three monthly physio reviews for frequent fallers. Falls risk and interventions are well documented in care plans that include the use of sensor mats and hip protectors.

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

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

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

Attainment and Risk: PA Low

Evidence:

Care plans are developed and reviewed by the RN's. The long term care plan is developed within three weeks of admission. All care plans have been reviewed and re-written in the new service provider format.

The care plan overall meet the residents needs and includes diagnosis/needs, aim and action. The first page of the long term care plan includes the resident details, medical problems, any special needs and name and signature of the resident/family member who has participated in the development of the long term care plan. The long term care plan describes needs as follows: hygiene and grooming, mobility, nutrition, continence, communication, cultural, rest and sleep, skin integrity, behaviour, medical and pain needs.

A 24 hour MDT (multidisciplinary) care plan is completed by the DT and RN. The MDT care plan details the residents morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. There is also an activities of daily living daily care plan in the resident files and mobility plans in resident rooms.

The activities person or family complete a resident activity profile sheet. The activity care plan identifies the resident's individual values, beliefs, spirituality and culture.

The care plans are monitored for integration of notes through the regular care plan audit last completed in February 2013, this audit has low score outcome, however the action plan and follow up education and interventions demonstrate this services commitment with the current comprehensive LTCPs n place . Service delivery plans demonstrate service integration.

D16.3k, Short term care plans are in use for changes in health status, however they are not consistently used and this is identified as an area for improvement.

D16.3f; Seven resident files reviewed identified that family were involved. Relatives interviewed confirmed they are involved in the care planning process.

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

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

Attainment and Risk: PA Low

Evidence:

Seven resident files reviewed. Care plan overall were resident centred and included interventions specific to the resident.

Finding:

(i)Of the seven resident files reviewed it was noted that care plan interventions were often documented in the evaluations section of the care plan (rather than the care interventions section). (ii) XXXXXX *This information has been deleted as it is specific to the health care of a resident. Who* did not have interventions documented on a STCP or the LTCP updated.

Corrective Action:

Ensure care plan interventions are documented in the intervention section of the LTCP and (ii) Ensure interventions to manage short term medical issues are documented on a STCP or the LTCP updated.

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity/DT staff and management. The GP interviewed was complementary regarding the care and support provided.

The care plans reflect the service philosophy of care and support.

Three hospital resident files and four rest home level care residents files sampled.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Wound assessments are comprehensive and include type, location and body map, graph, Braden score, classification, factors delaying healing and any additional information. There is a wound dressing schedule and photographs for chronic or acute wounds. There are twelve residents with wounds; Wound include two pressure sores, one ulcer, one surgical wound and ski tears. Wound assessments and treatment schedules are current. Specialist wound management advice is available as needed and this could be described by the RN's interviewed. Continence products are available and resident files include an admission urinary and bowel continence assessment that is reviewed at least six monthly or earlier if there are any changes in resident continence. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained. Specialist continence advice is available as needed and this could be described by the RN's interviewed. Staff attended continence management in-services November 2013.

Monitoring forms in use included behaviour monitoring, blood sugar levels, neuro observations and vital signs. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, and medication requests sighted in the resident files sampled.

The dietitian visits monthly and completes any resident reviews due and attends to any referrals received for example residents with weight loss, initiates special authority for supplements and liaises with the cook regarding any resident dietary changes/requirements. Residents are weighed monthly or more frequently as per the weight loss management policy

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Leighton House has three activities staff (one almost qualified) that work a variety of hours to implement a planned seven days activities programme. One activity person interviewed informed that a monthly conference with other diversional therapy staff across the organisation and the Diversional Therapy Coordinator at Christchurch takes place.

Activities staff are supported by a diversional therapy co-ordinator who provides over-sight and leadership to the recreation team. Activities are also discussed at teleconferences so that each facility can learn from each other.

The activity staff develop a monthly programme that is posted onto the noticeboard as well as a weekly planner that is also posted on notice boards and provided to residents in their room.

Each resident has a comprehensive individual activities plan which is reviewed as part of the six monthly care plan review process.

Resident preferences, including spiritual and cultural preferences and capabilities are considered in the delivery of the service activities programme.

Monthly resident meetings provide feedback regarding the activities and the service was able to show changes as a result of feedback (EG Bingo increased to twice a week and bowls tournaments with other facilities).

Regular church services are held monthly. Other spiritual visitors can be accessed on resident or family request.

Eight residents and four relatives praised the activities and the staff.

Over the two days of audit a variety of activities are observed happening.

D16.5d Resident files reviewed identified that the 24 hour individual activity plan is reviewed when at care plan review.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Nursing care plans are reviewed regularly and care plans are evaluated at least six monthly for rest home and hospital residents and more frequently when clinically indicated. A multidisciplinary six monthly review is also completed with input from the nursing and care staff, GP, physio, resident or family/whanau as appropriate. Short-term care plans are reviewed as required (link to 1.3.5.2). There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Discharge and Transfer Planning and Resident Transfer to Hospital (Acute) policies are available to guide staff in this process. The service has a physiotherapist that visits weekly and a dietitian that visits monthly. Residents' and/or their family/whanau are involved as appropriate when referral to another service occurs and four relatives agreed that they are always kept informed. Referrals sighted in the resident files sampled include: dietitian, wound nurse specialist and palliative care team.

D 20.1 Discussions with four registered nurses identified that the service has access to a physio, and a dietitian and also from nurse specialists from the DHB.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is a discharge planning and transfer policy and resident transfer to hospital (acute) policies to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. Discussions with the RN's and clinical manager confirm that resident exit from the service is co-ordinated and planned and relevant people are informed. There is a verbal handover where required to new service providers to ensure continuity of residents care.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) specific medication devices (such as spacers, oxygen, IV therapy, sub-cut fluid administration, novo-pen, etc.) h) medication errors, i) emergency medications, j) staff training, k) storage and administration of controlled drugs, l) alternative medication and m) medication audit.

The RN checks all medications on arrival from the supplying pharmacy. Medication reconciliation is implemented via the 'medication management on admission and transfer policy'. Registered nurses administer medications. Annual medication education is provided as part of the annual training programme and medication competencies are filed on individual staff files.

The medication folder contains standing orders, medication information folder on common medications, MOH medication guidelines and nutritional supplements list.

The facility has a medication trolley and locked medication storage area. Controlled drugs are stored in a locked safe in a locked cupboard. A CD register is maintained and checked weekly.

The hospital unit has emergency medications, suction and oxygen concentrator. The palliative care service is accessed for advice, resources and syringe drivers as required.

There are adequate pharmaceutical and medical supplies sighted. Eye drops are dated when opened. Medication expiry dates are checked four weekly. The medication fridge is monitored daily and temperatures are within range.

D16.5.e.i.2; 14 medication charts, (three hospital and 11 dementia care) reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. GP prescribing meets the legislative requirements.

All medication charts had current photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts. There are no gaps in the administration signing sheets.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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.

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:

There is a Kitchen Service Manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. There are two recently installed satellite kitchens in two of the wings.

The main kitchen provides food to all the kitchenettes in each unit. Food will be transported by hot boxes. Temperature checks are undertaken daily for the fridges, freezers, sanitizer, and hot foods at each meal time. Food in the pantry is stored off the floor and stock is rotated each week when the food order is delivered. Perishable food is covered and dated in the fridges.

The cooks have undertaken food safety and hygiene training. Food safety competencies are also completed. Kitchen hands assist the cook and there is an evening meal assistant. There is a four weekly menu in place. An organisational food services management consultant reviews and advises on menus 12 monthly and more often if necessary. The service also has access to a dietitian monthly for review of resident needs.

A resident dietary profile is undertaken on each resident on admission and a copy provided to the cook and updated as required by the RN's. Special diets (e.g. gluten-free), meal textures, likes and dislikes are known and catered for. Changes to residents' dietary needs are communicated to the kitchen.

Monthly weights are completed and where there is an issue this is addressed through the care planning process and communicated to the cooks. Special equipment is available as required such as lipped plates. Care plans include clear instructions for nutrition needs across the 24 hours. Nutrition and hydration is identified as a component of the care plan and these were noted in the seven resident files sample.

Feedback on the food service is received through staff and resident meetings. The cooks meet with management regularly. Kitchen service audits undertaken; food safety May 96% compliance.

Ecolab provide the chemicals and conduct quality control checks. Chemicals are stored safely. Common kitchen hazards are identified.

Meals viewed and interviews with residents (two hospital and six rest home) confirms that meals are prepared with care and residents enjoy them.

D19.2: staff have been trained in safe food handling

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:

Organisational policies of Management of Waste and Hazardous Materials policy and relevant procedures to support the safe disposal of waste and hazardous substances are in place. These include, but are not limited to: a) sharps procedure and b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled correctly and stored safely throughout the facility. There is appropriate protective equipment and clothing for staff.

Staff attended chemical safety training in Jan-13 and chemical safety competencies have been completed.

They are medical data safety sheets displayed. Staff interviewed were able to describe waste management and chemical safety procedures.

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.)*

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used 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.)*

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 building holds a current warrant of fitness, which expires 1 March 2015. The building is single storey and laid out in five wings, which link to reception. Fire equipment is checked by an external provider. Electrical equipment and hoists (i.e., one standing and one cradle/sling) are checked and medical equipment is calibrated. The communal living environment is spacious, as are all bedrooms and bathroom areas. Living areas are carpeted with new carpets and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms are carpeted and decorated according to personal choice. The corridors have handrails and are wide. Some bedrooms have double doors. Residents were observed moving freely around the areas with mobility aids where required. The external areas are very well maintained with large shaded sunrooms that overlook the river. There are ramps leading to the external areas. There are three lounge areas (the River Lounge, the Garden Lounge and the East wing lounge). Lounges have (new) satellite kitchens and dining areas. North wing of eleven beds is assessed as suitable for dual use (swing) beds for hospital and rest home. The rooms are all spacious, all have double doors and spacious ensuited bathrooms

ARC D15.3; The service continues to provide a wide range of equipment as needed for rest home and hospital level care, including (but to limited to) ; hospital beds including four hospital low-low beds, pressure relieving mattresses, shower chairs, two hoists (one standing and one sling). One shower area can accommodate a shower trolley if necessary.

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.)*

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.

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

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

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 1.4.3: 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

Attainment and Risk: FA

Evidence:

The facility has five wings (Admin wing, East wing, Garden wing, River wing and North wing).

The East wing and the admin wing are able to be used as hospital. As part of this audit the North wing was also review as appropriate for dual purpose (swing beds).

There are showers and toilets throughout the facility and they are of a good size to accommodate equipment including hoists and shower chairs. The showers are fitted with disability grab bars and handrails. The flooring in wet areas is all easy draining, non-slip surfaces. Showers and toilets have easy clean walls. There are 17 bedrooms with ensuites, 20 bedrooms that share ensuites, seven bedrooms that do not have ensuites and six double rooms all currently used as singles. There are adequate visitor and staff toilet facilities available. Communal toilets and bathrooms have appropriate signage and appropriate hand washing and drying facilities.

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.

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 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

The bedrooms are of differing sizes. They are spacious and can accommodate personal armchairs, walkers, wheel chairs, and hoists if needed (confirmed by observation and in discussion with the manager). Even the smallest bedroom in the facility is able to accommodate a hospital bed and a hoist. Many of the bedrooms have double doors to facilitate entry and exit. Most residents have personal furniture in their bedrooms and they were observed manoeuvring walkers safely

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There are three lounges with satellite kitchens and a sunroom that are all used for activities and or relaxation. In addition, a large dining room area can seat everyone very spaciouly at the same sitting. All communal areas can accommodate residents who use mobility aids (observed). Activities occur throughout the facility. Residents are able to move freely and the

placement of furniture facilitates this. Seating and space is arranged to allow both individual and group activities to occur. New carpets and painting is evident throughout the service.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to 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.)*

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

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

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

Attainment and Risk: FA

Evidence:

There are a range of laundry and cleaning policies in place to guide staff who work in these areas and a number of the important procedures are displayed on the walls (sighted). Cleaning is done by three cleaners who are employed Monday to Friday and one cleaner who is employed on the weekends.

All laundry is done by caregivers on morning and afternoon shift and ironing is done by night staff. The laundry has designated clean and dirty areas. Soaking of heavily stained clothes occurs. There is a sluice room for the disposal of soiled water or waste. Quality is monitored through resident satisfaction surveys, the complaints system and internal auditing. The last cleaning audit and laundry audits were done in March 2014 (97%). The laundry and cleaning room are designated areas, able to be locked when not in use and clearly labelled on external doors. Chemicals are stored appropriately and labelled with manufacturer's labels. Chemicals are supplied by Ecolab and Ecolab dispensers are used.

Interviews with residents and relatives confirmed satisfaction with the cleaning and laundry.

The 2014 resident survey identified 84% satisfaction with cleaning and 80% satisfaction with laundry.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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

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

Attainment and Risk: 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: FA

Evidence:

Appropriate equipment for responding to emergencies is available (confirmed in discussion with the operations manager). At least three days' supply of food is stored on site and nearly 4000 litres of water is stored in a water tank. There are blankets and alternative fuel supplies available. The building has an approved fire evacuation scheme, which was approved by the

NZ Fire Service on 9 April 2002. A fire drill occurred on April 2014 and evacuation. Staff have up to date first aid certificates. Visitors and contractors sign in and out. The building is secured at night. Emergency equipment is held on site and maintained in working order. There is a call bell system that has main indicator display panels located around the facility. During the tour of the facility, residents were observed to have easy access to call bells. Call bells are answered in a timely manner (observed).
D19.6: There is a DCNZ emergency management plan in place to ensure health, civil defence and other emergencies are included.

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: 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 1.4.7.3 (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 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

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

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All resident rooms have an external window, all rooms were observed to be warm and well ventilated. Power is a mix of electric and gas. The temperature of the facility is comfortable and is adjusted to suit the season. There are two external designated smoking areas for residents and staff to ensure people are not at risk of secondary smoke inhalation.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence such as a lap belt in a wheelchair. There is also a policy for enablers. There are no residents with enablers. There are currently no residents on the register assessed as requiring restraint.

There is a comprehensive assessment process documented which includes relevant forms. The service is required to review the entire care plan monthly if a resident has restraint and this was documented well in the one (previous) restraint file reviewed.

The assessment/approval and evaluation process is undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The service also completes post-restraint surveys (two reviewed for previous restraint episodes January 2014).

Restraint competencies/ training has been provided to staff.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme is reviewed annually (November 2013), this was completed with ICNs across the organisations.

The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level.

There is an established and implemented infection control programme that is linked into the objectives of the quality and risk management plan for 2014. The IC programme includes seven objectives that include performance indicators and evaluation. There is site-specific goal to reduce UTI's to below the NZ average in the benchmarking, and to continue to have low traumatic wound infections.

The IC meeting meets monthly and at an organisational level six monthly. The facility has access to professional advice within the organisation, from GP's and from an IC consultant.

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines.

There has recently been a Norovirus outbreak between 5 May and 14 May 2014. This was contained to six residents and two staff. The outbreak management policy was implemented. Outbreak management meetings were held during this time with support and involvement of Public Health

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The monthly infection control committee meeting includes IC as an agenda item. The IC committee is made up of a cross section of staff from across the service. The service also has access to IC consultant, Public Health, GP's and local community laboratory infection control team. The IC nurse reviews support from the organisation staff trainer, and she has completed a MOH IC e-learning course.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

The Infection Control Manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Policy development involves the organisation IC nurses, the infection control committee and expertise from the regional clinical manager, quality and systems manager, and local community laboratory. The manual included a list of amended policies.

The DCNZ policies have been implemented at Leighton House since change of owner July 2013. Caregivers interviewed described completing IC competencies.

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Infection control programme includes infection control objectives as part of the quality and risk management plan. Policies include (but not limited to); a) hand hygiene, b) standard precautions c) transmission-based precautions, d) prevention and management of infection in staff, e) antimicrobial usage, f) pandemic planning, g) cleaning, disinfection, sterilisation, h) single use items, i) IC nurse duty schedule guidelines, j) IC education and staff training, k) IC education for residents and family.

The Infection Control Manual is structured around four sections includes (but is not limited to):

Section 1: directors commitment/IC programme

Section 2: staff responsibilities for IC

Section 3: IC policies and procedures

Section 4: Management of waste and hazardous materials

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control nurse is responsible for co-ordinating/providing education and training to staff and is supported by the clinical manager. There are internal and external sessions available for training. The IC nurse has completed IC training online. IC training has been provided to staff 25 March 2014 and staff have complete IC competencies. Resident/family education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of visitor education in the form of hand hygiene signs around the facility and at entrance ways. There is policy around provision of infection control education for family members. Advised that the three monthly family newsletter and family meetings are an opportunity for them to include relevant infection prevention information. The family and resident noticeboard also includes current IC issues.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The infection surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and med lab infection control team who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly infection control meeting. Infections are documented on the infection monthly register.

The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality and risk management plan 2014 and IC plan 2014. The service benchmarks with other organisation owned services on a range of issues - infection control being one of them. Reports are also completed for benchmarking analysis in the Quality Report. Infection control surveillance outcomes are reported to all meetings and provided on the staff noticeboard. Analysis of trends is included in infection control meetings and an action plan established around good practice.

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.)*