

# Presbyterian Support Services (South Canterbury) Incorporated - The Croft Complex

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Current Status: 10 April 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

## General overview

The Croft, (Presbyterian Support South Canterbury), provides care and support for up to 60 residents at three service levels, including hospital (geriatric/medical), resthome and dementia level care. On the day of audit there were 23 residents in the dementia unit, 28 hospital level residents and eight rest home level residents. The Presbyterian Support South Canterbury has three residential care homes that are governed by a board of trustees.

One of four shortfalls identified at the previous audit around residents' personal belongings has been addressed. There continues to be improvements required around resuscitation orders, incident forms, risk assessments and medication management.

This surveillance audit also identified improvements required around resident care plan interventions, corrective action plans, admission agreement, short term care plans and six monthly review of care plans, staff competency in medication management and self administration of medication by residents.

## Audit Summary as at 10 April 2013

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

### Consumer Rights as at 10 April 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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### Organisational Management as at 10 April 2013

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 medium or high risk and/or unattained and of low risk.
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### Continuum of Service Delivery as at 10 April 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 10 April 2013

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 10 April 2013

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 10 April 2013

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Presbyterian Support Services (South Canterbury) Incorporated
<b>Certificate name:</b>	Presbyterian Support Services (South Canterbury) Incorporated - The Croft Complex
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	The Croft Complex (Rest Home, Hospital, Dementia Care)
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care and dementia care
<b>Dates of audit:</b>	<b>Start date:</b> 10 April 2013 <b>End date:</b> 11 April 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	59

## Audit Team

<b>Lead Auditor</b>	XXXXXXXXXX	<b>Hours on site</b>	13.5	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXXXXXXX	<b>Total hours on site</b>	13.5	<b>Total hours off site</b>	6
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	27	Total audit hours off site	16	Total audit hours	43
Number of residents interviewed	5	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	9	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	18	Total number of staff (headcount)	96	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Thursday, 15 May 2014

## Executive Summary of Audit

### General Overview

The Croft, (Presbyterian Support South Canterbury), provides care and support for up to 60 residents at three service levels, including hospital (geriatric/medical), resthome and dementia level care. On the day of audit there were 23 residents in the dementia unit, 28 hospital level residents and eight rest home level residents. The Presbyterian Support South Canterbury has three residential care homes that are governed by a board of trustees. One of four shortfalls identified at the previous audit around residents' personal belongings has been addressed. There continues to be improvements required around resuscitation orders, incident forms, risk assessments and medication management. This surveillance audit also identified improvements required around resident care plan interventions, corrective action plans, admission agreement, short term care plans and six monthly review of care plans, staff competency in medication management and self administration of medication by residents.

### Outcome 1.1: Consumer Rights

An open disclosure policy is documented. Interpreter services are available, if required. The complaints process is made known to residents and families on admission and displayed in the facility. Staff, residents and family interviewed demonstrate an understanding of the complaints process. A complaints register is maintained and up to date. There are areas requiring improvement around the admission agreement and residents' resuscitation orders.

### Outcome 1.2: Organisational Management

The Croft, Presbyterian Support South Canterbury has established systems in place which define the scope, direction and goals of the organisation and the facility and monitoring and reporting processes against these systems. The Croft has a quality and risk management system in place. Quality improvement data is reported on to the governing body monthly. Monitoring and communication of quality improvement data occurs via facilities meetings, notices and newsletters. Internal audits and resident and family surveys are conducted, however corrective actions are not always documented and implemented and this requires an improvement.

The Croft is managed by nurse manager, registered nurse, who has been in this position for seven years. The nurse manager is supported by the eldercare manager and the chief executive officer.

The adverse event reporting system is in place. There is evidence in the residents' files reviewed of adverse event reporting and this is also reported on monthly. The adverse event forms do not always record communication with families following adverse events and the forms are not fully completed and this requires an improvement.

Health and safety policies, systems and processes are implemented to manage risk.

The human resource management systems provide for the implementation of processes both at the start of employment and on an ongoing basis in relation to education and training. There are regular in-service education and training opportunities provided for staff. A sampling of staff records evidences human

resource processes are followed.

There is a documented rationale for determining staff levels and staff skill mixes. There is a registered nurse on duty 24 hours a day with on-call support from the nurse manager and the clinical coordinator. 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**

Resident files reviewed include service coordination centre assessment forms. The facility information pack is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments and initial care plan are completed on admission. Residents and/or family have input into the development of care plans. There are improvements required around risk assessments and care plan interventions.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly and there is a separate programme for the rest home/hospital and the dementia unit.

Policies and procedures around medication management system detail service provider's responsibilities. Medication charts sighted evidence documentation of residents' allergies/sensitivities. There are improvements required around six monthly controlled drug stocktake, three monthly medication reviews completed by general practitioners, 'as required' medication prescribing, medication administration, review of competencies for residents who self-administer medicines and medication competency assessments for staff administering medications.

A dietitian is available to provide dietetic assessment for residents and arrange special authority, as required. All food is cooked on site and the chef and the cook have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

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

There is a current building warrant of fitness.

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

There are documented definitions of restraint and enablers that align with the definition in the standards. The service currently has no residents assessed as requiring restraints or enablers.

### **Outcome 3: Infection Prevention and Control**

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	11	0	3	5	0	0
<b>Criteria</b>	0	34	0	3	7	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	31
<b>Criteria</b>	0	0	0	0	0	0	0	57

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The admission agreement does not contain all relevant information required. Review of the admission agreement evidences the complaint process; exclusions from services and transportation cost do not record the required elements, as per the ARC contract. Interview with the Eldercare manager confirms this.	Provide evidence the admission agreement contains all required information, as per the ARC contract.	180
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		choices and give informed consent.				
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	One of nine resident's files sampled evidences a completed resuscitation form. One of nine files evidences the resuscitation form was incomplete and the remaining seven files did not have resuscitation orders completed. The resuscitation policy sighted states the resuscitation decisions should be reviewed annually or when significant events occur.	Provide evidence of residents' completed resuscitation forms.	90
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Results of the residents' survey conducted in May 2013 record three areas below the 90 % accepted rating by the organisation, however there is no evidence of corrective action plan and implementation of the plan. There is no recorded evidence of the survey results communicated to resident, family or staff. Eden family and residents surveys conducted in April 2013 do not evidence documentation or implementation of corrective actions following analysis of the survey results. Medication management audit conducted in September 2013 evidences analysis is recorded, however there is no date or signature	Provide evidence corrective action plans addressing areas requiring improvement are developed and implemented following resident and family surveys and internal audits and results are communicated to all concerned.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				of the person compiling this information. There is no corrective action plan recorded for the areas identified as requiring improvement.		
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 Moderate			
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 Moderate	Adverse event forms are not consistently fully completed and events are not consistently communicated to family. Neurological observation following falls resulting in head injury were not recorded for two of three residents files reviewed. Two residents did not have neurological observations completed following a fall with head injury. Additional incident form was reviewed for a resident post fall with head injury and the resident's clinical file was sampled in respect of this. The resident's file records neurological observations were conducted, however were insufficient. The observations were recorded half hour post fall and pupil reaction to light was first recorded two hours post fall. Sighted 11 incident forms ( seven falls, three skin tears and one choking incident) and associated residents' files. Of the 11 incident forms, six forms did not indicate	Provide evidence adverse event forms are fully completed, family are notified of events and neurological observations are conducted for residents with head injury.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				family have been notified of the event. The corresponding residents' files did not record family notification in progress notes. There was no level of risk recorded in two of 11 incident forms completed. All 11 incident forms were incomplete and did not evidence follow up actions.		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	(i) One resident from the rest home does not have a nutritional assessment and second resident did not have a pain assessment. (ii) One resident from the hospital XXXXX does not have falls risk, pressure area risk and nutritional assessment completed until three months after admission. (iii) One resident from the hospital does not have a continence assessment, nutritional assessment and there is no documented date for the pressure area assessment noted as high risk. (iv) One resident from the hospital does not have a continence assessment.	Ensure risk assessments are completed on admission, reviewed regularly and dated.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			

HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Challenging behaviours assessments are completed in three files sampled from the dementia unit. However, triggers for behaviours and de-escalation techniques are not documented.	Ensure that all residents who exhibit behaviours that challenge have a behaviour assessment completed and that triggers for behaviours are identified and management plans / strategies are recorded on resident's care plan as per the ARC contract.	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	i)Two of the rest home care plans do not show evidence that they had been reviewed six monthly. ii) Three files (one rest home, one dementia and one hospital) do not show evidence of short-term care plans for identified weight loss issues. Additional five residents' files were reviewed with the infection control coordinator in respect of recent reported infections and documentation of same on a short-term care plan or long-term care plan amendment. Two of the five files evidence short term care plans for short-term problems.	(i)Ensure that evaluations of files are carried out at least six monthly. (ii) Ensure that short-term care plans are initiated for acute identified needs.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			

HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	(i) Six monthly controlled drugs stock take are not completed. (ii) Six of 18 (one from the rest home, two from Grant Home and three from the hospital) medication charts have not been reviewed three monthly by the GP. (iii) Seven of 18 (one rest home, two Grant Home and four hospital) medication charts do not have indication for use for PRN medications documented by the GP. (iv) Oxygen has not been charted (one dementia and one hospital) and nitrolingual spray has not been charted (one hospital). This was discussed with the GP during the GP interview.	Ensure six monthly controlled drug stock take is undertaken. (ii) Ensure that the GP reviews the medication charts three monthly. (iii) Ensure PRN medications document indication for use. (iv) Ensure all medications are charted by the GP.	90
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	All staff that administer medicines do not have current medication competency assessments. Interview with the nurse manager and the Eldercare manager confirms education in medication management has not been provided for RN and staff that administer medicines have not been assessed to be competent in 2013 and 2014. RN medication competency assessments have not been conducted by the organisation since 2010	Ensure all staff that administer medicines have current medication competency assessments.	90

HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	One hospital resident and one rest home resident do not have competency assessment completed to self-administer medications. Interview with the hospital resident evidences that the resident was confused when to take inhalers. Staff had signed for inhaler that was not taken until the auditor was present. Interview with the rest home resident evidences that the resident was not clear on when to take the eye drops.	Ensure that competency assessments are completed for residents self-administering medications.	90
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## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

### **Standard 1.1.3: 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

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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The previous certification audit identified an area requiring improvement around the service not having resident's personal belongings policy and no record of personal belongings on nine residents files sampled.
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At this surveillance audit there is evidence of a policy around safe guarding resident's property and resident's property lists were sighted in the files reviewed. There are instructions provided to residents on entry regarding responsibilities of personal belonging in the admission agreement.
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Residents are treated with respect by staff, observed on audit days. Staff receive training on abuse / neglect, the last training was provided in May 2013. Staff are observed to knock before entering residents' rooms and to keep doors closed when attending to residents. Residents can attend community events, clubs and churches. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Five of five residents (three rest home and two hospital) interviewed confirm, that this is the case.
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Values, beliefs and cultural aspects of care are recorded in residents' clinical files. Residents interviewed state that values, beliefs and cultural aspects of care are respected by staff. Staff education on beliefs and spirituality was conducted as part of a study day in February 2014 and attended by 12 staff.
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### **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.

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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<b>Finding:</b>
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**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:** PA Low

**Evidence:**

There is open disclosure policy in the facility, sighted.

Residents ( three rest home and two hospital) and family members (one rest home and three dementia) interviewed confirm that staff and management communicate well with them.

The nurse manager advises there are no residents requiring interpreter services at time of audit.

Incident forms and residents' progress notes do not consistently evidence family are informed of adverse events (link # 1.2.4.3).

Residents' and family surveys conducted in 2013 do not evidence communication of survey results to residents, family and staff (link # 1.2.3.8).

A13.1 & A 13.2; Full details of items that are excluded from the services are not clearly set out in the Admission Agreement and this requires an improvement.

D11.3; Service information is available and appropriate to the communication needs and capabilities of the residents, families and referring agencies.

D12.1 & D12.3a & D12.4 & D12.5 & D16.1bii) The Admission Agreement does not contains all required information, such as complaint management and transportation cost and this requires an improvement.

### **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:** PA Low

**Evidence:**

Interview with management confirms residents and family members are provided with admission agreement. Admission agreement is signed by resident or resident's representative on day of admission. Residents ( three rest home and two hospital) and family members (one rest home and three dementia) interviewed confirm that staff and management communicate well with them.

**Finding:**

The admission agreement does not contain all relevant information required. Review of the admission agreement evidences the complaint process;

exclusions from services and transportation cost do not record the required elements, as per the ARC contract. Interview with the Eldercare manager confirms this.

**Corrective Action:**

Provide evidence the admission agreement contains all required information, as per the ARC contract.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The last certification audit identified an area requiring improvement around resuscitation forms reviewed in nine resident files noted that seven did not document that family / the resident had advanced directives discussed with them and the forms did not give clear direction to staff as to the resuscitation status.

This finding remains requiring improvement following this surveillance audit. There is evidence of one of nine files being completed in respect of resuscitation orders.

There is a policy on informed consent and resuscitation policy, sighted. Consent form relating to clinical care and organisational care were sighted in residents' file sample. There are consent forms located on residents' files and these include consent for transport, release of resident's name, student

involvement in treatment/care and taking of resident's photographs.

The admission agreement contains statements of consent for treatment and care, release of health information, consent regarding privacy and confidentiality of resident records, consent for photographs and resident's name of doors of bedrooms and medication management.

There is currently a project being undertaken to review the complete End of Life care. This had only just started as they have been waiting for the Nurse Manager to attend a two and half day course on Advanced Care Planning. This had taken place in the third week of March.

**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.

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

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

The service is able to demonstrate that written consent is obtained where required.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Resuscitation policy records guidelines around obtaining resuscitation status of residents.

**Finding:**

One of nine resident's files sampled evidences a completed resuscitation form. One of nine files evidences the resuscitation form was incomplete and the remaining seven files did not have resuscitation orders completed. The resuscitation policy sighted states the resuscitation decisions should be reviewed annually or when significant events occur.

**Corrective Action:**

Provide evidence of residents' completed resuscitation forms.

**Timeframe (days):** 90 (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 Presbyterian Support South Canterbury (PSSC) organisational wide complaints policy and procedures are congruent with Right 10 of the Code of Rights.

There is a complaints register, which is current and monitored by the chief executive officer (CEO). Complaints for 2013 and 2014 were reviewed.

There is recorded evidence that the complaints are acknowledged in writing within five working days of receipt, the complainant is informed of the availability of independent advocates and records of investigations and actions taken by the facility. The complainant is kept informed of the progress towards resolution of the complaint according to timeframes set out in policy and the Code of Rights.

There is a six monthly summary of complaints documented, sighted (June 2013 to December 2013). The complaints summary records number of complaints, identification of the complainant (staff, volunteer, resident, family, external individuals), number of resolved complaints and any change in policy or procedure required as result of a complaint. All complaints are closed off.

Staff education on complaints processes was last conducted during the education day in November 2013 and staff interviews confirm they are aware of the complaints process.

The complaints process documentation is included in the facility information booklet and located at the facility, however the complaints process is not part of the admission agreement (D13.3h) (link# 1.1.9.1).

Five of five residents (three rest home and two hospital) and four of four family members (one rest home and three dementia) interviewed are aware of the complaints processes. Health and Disability Commissioner (HDC) brochures on Code of Rights and Learning from Complaints are displayed throughout the facility. The Nationwide Advocacy Service and the HDC contact details are available at the facility.

The management team (CEO, nurse manager, Eldercare manager) state there have not been any complaints since the last certification audit, referred to the Health and Disability Commission, police, coroner, accident corporation or Ministry of Health.

D6.2; Information about the complaints system, including how to make a complaint and the role of independent advocacy services and the Health and Disability Commissioner are communicated in writing to the resident and their family in the information booklet and located in facility on notice board (link# 1.1.9.1.).

D13.3h; The Admission agreement does not contain the procedure to follow to make a complaint (link #1.1.9.1).

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

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

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

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

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

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

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

## Outcome 1.2: Organisational Management

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

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

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

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>The Presbyterian Support South Canterbury (PSSC) has systems in place which record the scope, direction and goals of the organisation and the facility. Monthly reports to the governing body are provided by management, sighted. PSSC mission statement, vision and values and philosophy are communicated to residents and their family. The Croft business plan was sighted.</p> <p>The nurse manager is a registered nurse (RN) with current practising certificate and has been in this position for seven years. The nurse manager is supported in their role by clinical coordinator (RN) and the Eldercare manager (RN). The nurse manager holds a post graduate certificate in leadership and management in nursing and national certificate in business. The nurse manager report to the Eldercare manager and the senior management team. The Croft organisational chart was sighted.</p> <p>All staff requiring practising certificates have current practising certificates, sighted.</p> <p>The Croft has contracts with South Canterbury District Heath Board (SCDHB) for aged related residential care for hospital services (medical and geriatric), rest home services; aged related residential respite care and dementia care. Sighted correspondence from the SCDHB in respect of the approval for 23 bed dementia unit, as per ARC contract E3.3a.</p> <p>D5.1 &amp; D5.2 &amp; D5.3; Services philosophy is documented and available to residents and families and referring agencies and staff. The philosophy is in a form that is easily understood.</p> <p>D17.3d &amp; D17.4b &amp; D17.5 The manager holds a current qualification or has experience relevant to both management and the health and personal care of older people and is able to show evidence of maintaining at least eight hours annually of professional development activities relating to managing a rest</p>

home/ hospital and dementia care.

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are quality and risk management systems in place including a clinical risk management plan and quality improvement policy, sighted. There is evidence the quality improvement data is collected, collated, evaluated, and analysed to identify trends, however corrective actions plans are not consistently documented and implemented and this requires an improvement.

The Presbyterian Support South Canterbury (PSSC) quality framework 2013-2014 and PSSC quality plan were sighted and evidence documentation and reporting of quality activities. The quality plan (2013- 2014) records quality principles and goals.

Core quality activities planner records annual quality activities and timeframes. Quality indicators are recorded for falls, pressure areas, medication errors, staff injuries, and infection rates and benchmarked with two other residential care facilities within the organisation.

Sighted 2013 -2018 strategic plan and strategic goals. Board meeting minutes were sighted. Sighted continuous quality improvement meeting minutes for 2014.

An internal audit schedule and completed audits for 2013 and 2014 were reviewed. Quality and risk management data and quality improvement data is reported at the facility's meetings. Meeting minutes reviewed evidence this. Sighted resident meeting minutes for June, August, September and November 2013.

Policies and procedures reflect current accepted good practice and reference legislative requirements. Staff interviews (six care givers, three registered nurses, one clinical coordinator) confirm staff are informed of new / updated policies. Document control policy and procedure for new or reviewed documents is recorded and implemented, sighted.

Health and safety manual documents health and safety management. Health and safety education was part of the staff education day in September 2013. (16 staff attended). PSSC holds Workplace Safety Management Practices for workplace safety and this expires on 31 August 2014.

Residents and family satisfaction surveys were conducted, however there is no recorded evidence of actions taken in response to the survey results and this requires an improvement.

A4.1 & D5.4 Policies and procedures for all elements of the service are developed, documented, reviewed and updated and implemented and staff are informed of the policies and procedures.

D17.7a & D17.7b & D17.7 e; RNs and care staff carrying out a delegated medical task or specialised procedure or treatment have not always demonstrated prior competency, such as medication competencies (link # 1.3.12.3)

**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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Resident survey was conducted in May 2013. The nurse manager states the survey questionnaire was revised in 2013. The current resident survey questionnaire contains three questions around quality of service, the service making a positive difference to resident's life and a question around the service helping to overcome loneliness, helplessness and boredom. The nurse manager states residents in the dementia unit; rest home and hospital participated in this survey. Eden family survey was conducted in April 2013, results sighted (69% return rate). Eden residents survey was conducted in April 2013, results sighted (20% return rate). Eden warmth resident survey was conducted in September 2013 (92% return rate) and this survey evidences corrective action plan and commencement of implementation of same.

<p><b>Finding:</b></p> <p>Results of the residents' survey conducted in May 2013 record three areas below the 90 % accepted rating by the organisation, however there is no evidence of corrective action plan and implementation of the plan. There is no recorded evidence of the survey results communicated to resident, family or staff.</p> <p>Eden family and residents surveys conducted in April 2013 do not evidence documentation or implementation of corrective actions following analysis of the survey results.</p> <p>Medication management audit conducted in September 2013 evidences analysis is recorded, however there is no date or signature of the person compiling this information. There is no corrective action plan recorded for the areas identified as requiring improvement.</p>
<p><b>Corrective Action:</b></p> <p>Provide evidence corrective action plans addressing areas requiring improvement are developed and implemented following resident and family surveys and internal audits and results are communicated to all concerned.</p>
<p><b>Timeframe (days):</b> 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</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.

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

### 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 Moderate

**Evidence:**

There is an incident reporting and analysis policy in place, sighted. All accident/incidents are recorded and reported on as part of the monthly clinical indicators. Communication with families following adverse events, or any change in resident's condition is not always evidenced on the incident forms or in the residents' progress notes reviewed and this requires an improvement.

Staff education in adverse reporting was last conducted during the education day in November 2013 (17 staff attended) and staff interviews confirm awareness of the adverse event process.

Staff are made aware of their essential notification responsibilities through their job descriptions, policies and procedures and professional codes of conduct.

Last certification audit identified an area requiring improvement around falls resulting in head injuries did not evidence neurological recording were conducted and this finding remains following this surveillance audit.

### 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 Moderate

**Evidence:**

There is an incident reporting and analysis policy and all accident/incidents are recorded and reported on as part of the monthly clinical indicators. Last certification audit identified an area requiring improvement around falls resulting in head injuries not having neurological recording conducted and this finding remains following this surveillance audit.

**Finding:**

Adverse event forms are not consistently fully completed and events are not consistently communicated to family. Neurological observation following falls resulting in head injury were not recorded for two of three residents files reviewed. Two residents did not have neurological observations completed following a fall with head injury. Additional incident form was reviewed for a resident post fall with head injury and the resident's clinical file was sampled in respect of this. The resident's file records neurological observations were conducted, however were insufficient. The observations were recorded half hour post fall and pupil reaction to light was first recorded two hours post fall. Sighted 11 incident forms ( seven falls, three skin tears and one choking incident) and associated residents' files. Of the 11 incident forms, six forms did not indicate family have been notified of the event. The corresponding residents' files did not record family notification in progress notes. There was no level of risk recorded in two of 11 incident forms completed. All 11 incident forms were incomplete and did not evidence follow up actions.

**Corrective Action:**

Provide evidence adverse event forms are fully completed, family are notified of events and neurological observations are conducted for residents with head injury.

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

There are policies and procedures in relation to human resource management. There is a planned and documented staff in-service education plan and staff attendance records are maintained, sighted for 2013 and 2014 in-service education plan and staff attendance records. The organisation provides four study days a year for staff. Each education day or in service education /training is documented in staff development summary and includes attendance numbers, evaluation sheets numbers, returns, comments from staff from evaluations and overall satisfaction with the training and areas identified for improvement

Annual practising certificates are current for all staff who require them to practice.

An orientation/induction programme is available and all new staff are required to complete this. Staff interviews confirm orientation / induction is provided for new staff. Orientation study days are conducted and include manual handling, documentation, dementia care, communication, continence management, infection control, Code of Rights and restraint minimisation.

Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

Nine of nine staff files evidence human resources systems are adhered to.

D17.6; All staff who are in direct contact with residents have completed education that is related to the care of older people. The staff who have not completed the training at appointment have completed appropriate training within six months of appointment.

**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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented staffing rationale policies for determining staffing levels and skill mixes.

Staff interviews confirm staff are able to get through their work.

Residents interviewed state the care they receive is appropriate to their needs.

Rosters evidence the nurse manager (RN) and the clinical coordinator (RN) work Monday to Friday and on call after hours. There is a registered nurse cover 24/7.

D17.1; Staff who require registration to practice have current annual practising certificates issued by the relevant responsible authorities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.2, 3, 4: The nine resident files reviewed (two rest home, three dementia and four hospital) identify that an initial nursing assessment is completed in all nine files. Daily care plans were completed within 24 hours that describe interventions to guide staff in providing care to residents for all nine files. All nine files have long-term care plans completed within three weeks of admission. Three of nine care plans evidence evaluations are completed at least six monthly. Two of the files from the rest home do not evidence that the files were reviewed six monthly. This is an area for improvement. Four residents have not yet been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the activities coordinators.

D16.5e: All resident files reviewed identify that the General Practitioner (GP) had seen the resident within two working days of admission. Three monthly or more frequent GP review is evidenced as occurring on review of resident's files.

Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Nine files reviewed identify integration of allied health and a team approach is evident. The GP interviewed reports that the registered nurses consult with the GP with any concerns regarding residents' health status and the GP believes the service meets resident's needs. The GP routinely visits weekly but frequently visits more often and is available at all times for urgent matters.

Tracer methodology rest home:

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

Tracer methodology dementia:

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

Tracer methodology hospital:

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

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

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

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

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

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

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

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

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

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

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

**Standard 1.3.4: 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

<b>Attainment and Risk:</b> PA Moderate
<p><b>Evidence:</b></p> <p>The nine resident files reviewed (two rest home, three dementia and four hospital) identify that an initial nursing assessment was completed in all nine files. Daily care plans were completed within 24 hours, which describe interventions to guide staff in providing care to residents for all nine files. All nine files had long-term care plans completed within three weeks of admission. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs, likes, and dislikes. Assessments are conducted in an appropriate and private manner. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. The service has recently commenced using InterRAI for new residents. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. One resident from the rest home did not have a pain assessment. One resident from the rest home does not have a nutritional assessment. One resident from the hospital on XXXXXX does not have falls risk, pressure area risk and nutritional assessment completed until three months after admission. One resident from the hospital does not have a continence assessment, nutritional assessment and there was not documented date for the pressure area assessment, which was noted as high risk. One resident from the hospital does not have a continence assessment. This is an area for improvement. This was a previous finding at last certification audit. Family members interviewed (one rest home and three dementia) confirm satisfaction with services provided.</p> <p>ARC E4.2: Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.</p> <p>E4.2 a. Challenging behaviours assessments are completed in three files sampled from the dementia unit. No files in the dementia unit identify triggers for behaviours with management plans. This is a further area requiring improvement.</p>

### 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.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> One resident from the rest home does not have a pain assessment. One resident from the rest home does not have a nutritional assessment. One resident from the hospital on XXXXXXXX does not have falls risk, pressure area risk and nutritional assessment completed until three months after admission. One resident from the hospital does not have a continence assessment, nutritional assessment and there is no documented date for the pressure area assessment, which was noted as high risk. One resident from the hospital does not have a continence assessment. This was a previous finding (criterion 1.3.4.1) at last certification audit. Family members interviewed (one rest home and three dementia) confirm satisfaction with services provided. ARC E4.2: Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.
<b>Finding:</b> (i) One resident from the rest home does not have a nutritional assessment and second resident did not have a pain assessment. (ii) One resident from the hospital on XXXXXXXX does not have falls risk, pressure area risk and nutritional assessment completed until three months after admission. (iii) One resident from the hospital does not have a continence assessment, nutritional assessment and there is no documented date for the pressure area assessment noted as high risk. (iv) One resident from the hospital does not have a continence assessment.
<b>Corrective Action:</b> Ensure risk assessments are completed on admission, reviewed regularly and dated.
<b>Timeframe (days):</b> 90 (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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> D16.2, 3, 4: The nine resident files reviewed (two rest home, three dementia and four hospital) identify that an initial nursing assessment was completed in all nine files. Daily care plans were completed within 24 hours that describe interventions to guide staff in providing care to residents for all nine files. All nine files had long-term care plans completed within three weeks. Three of nine care plans evidenced evaluations completed at least six monthly. Two of the files from the rest home does not evidence that the files were reviewed six monthly. Four residents have not yet been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the activities co-ordinators. The care being provided is consistent

with the needs of residents. This is evidenced by discussions with residents, family members, caregivers, the registered nurses, clinical coordinator and the nurse manager (RN).

A review of short-term care plans, long-term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews. The nurse manager is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers at least daily (evidenced in all nine residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral (link 1.3.8.3).

Six caregivers (four working in rest home/hospital and two working in dementia unit), two registered nurses (RN), one clinical coordinator (RN) and the nurse manager (RN) interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted.

Five residents interviewed (three rest home and two hospital) and four family (one the rest home and three from the dementia unit) interviewed are complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management (link # 1.3.4.2). Specialist continence advice is available as needed and this could be described.

Continence management in-services was last conducted during staff study days in September 2013.

During the tour of facility, it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.

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

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

**Attainment and Risk:** PA Moderate

#### **Evidence:**

The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, registered nurses, clinical co-ordinator and the nurse manager. A review of residents' files including short-term care plans, long-term care plans, evaluations and progress notes demonstrate integration. There is evidence of three monthly medical reviews. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers at least daily (evidenced in all nine residents' progress notes sighted). Five residents interviewed (three rest home and two hospital) and four family (one the rest home and three from the dementia unit) interviewed are complimentary of care received at the facility.

E4.3iii. Challenging behaviours assessments are completed in three files sampled from the dementia unit. No files in the dementia unit identify triggers for behaviours with management plans. This is an area requiring improvement.

#### **Finding:**

Challenging behaviours assessments are completed in three files sampled from the dementia unit. However, triggers for behaviours and de-escalation

techniques are not documented.

**Corrective Action:**

Ensure that all residents who exhibit behaviours that challenge have a behaviour assessment completed and that triggers for behaviours are identified and management plans / strategies are recorded on resident's care plan as per the ARC contract.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are four activities coordinators at The Croft who are responsible for the planning and delivery of the activities programme. One of these staff completed diversional therapy training five years ago. This staff member is also the secretary for South Canterbury diversional therapy group where ideas are shared about programmes. Three of the staff work for fifty-six hours per two weeks and one staff member works 26 hours per two weeks. Two staff are on daily including weekends. One staff member works in Grant Home (dementia) and one in Hubbard (rest home and hospital). There is a separate programme for the dementia unit and the rest home/hospital. Residents can choose which programme activity they would like to attend with staff supervision. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms, when required. On the day of audit, residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. The programme includes residents being involved within the community with social clubs, churches, schools and kindergarten. On or soon after admission, a social client profile is taken and information from this is added into the long-term life style care plan and this is reviewed six monthly, as part of the care plan review/evaluation (link # 1.3.8.3). A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. The Croft has its own van for transportation. Residents and relatives interviewed reported being very happy with the activities programme and felt it catered for their needs. There are a wide range of activities available for caregivers to engage with residents in the dementia unit across the 24 hour period and caregivers were observed to be engaging residents in a variety of activities during the audit. D16.5d.; Resident files reviewed identify that the individual activity plan is reviewed at care plan review (link # 1.3.8.3).

**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.

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

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>There is at least a three monthly review by the general practitioner (GP). D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in three of nine care plans sampled. Two of the files from the rest home do not evidence that the files had been reviewed six monthly. Four of the files have not been at the facility for more than six months. (Link # 1.3.8.3). There are short-term care plans (STCP) to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Three files (one rest home, one dementia and one hospital) do not show evidence of short-term care plans for identified weight loss issues. This is an area for improvement. Caregivers interviewed confirm that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.</p>

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

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

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

**Criterion 1.3.8.3 (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.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Two of the files from the rest home do not evidence that the files had been reviewed six monthly. Four of the files have not been at the facility for more than six months. Three files (one rest home, one dementia and one hospital) do not show evidence of short-term care plans for identified weight loss issues. Caregivers interviewed confirm that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.
<b>Finding:</b> i)Two of the rest home care plans do not show evidence that they had been reviewed six monthly. ii) Three files (one rest home, one dementia and one hospital) do not show evidence of short-term care plans for identified weight loss issues. Additional five residents' files were reviewed with the infection control coordinator in respect of recent reported infections and documentation of same on a short-term care plan or long-term care plan amendment. Two of the five files evidence short term care plans for short-term problems.
<b>Corrective Action:</b> (i)Ensure that evaluations of files are carried out at least six monthly. (ii) Ensure that short-term care plans are initiated for acute identified needs.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in three locked trolleys, which are chained to the wall in the nursing office in the rest home and hospital and in a locked trolley in a locked office in Grant Home (dementia unit). Controlled drugs are stored in a locked safe in the hospital nurses office and two medication competent persons must sign controlled drugs out (link # 1.3.12.3). Weekly checks of controlled drugs are completed.

Six monthly controlled drugs stock take have not been completed. This is an area for improvement.

The registered nurse administers medications in the hospital. Senior caregivers and registered nurse administers medications in the rest home Grant Home. Staff competencies for administering medications are not up to date. This is an area for improvement. The service uses four weekly blister packs medication management system. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by the registered nurse and a caregiver and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet.

D16.5.e.i.2; Six of 18 (one from the rest home, two from Grant Home and three from the hospital) medication charts have not been reviewed three monthly by the GP. Seven of 18 (one rest home, two Grant Home and four hospital) medication charts do not have indication for use for PRN medications documented by the GP. Two residents that are self- administrating medications do not have competency assessments completed. These are areas for improvement. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name.

Education on medication management occurred in March 2014 for enrolled nurses (ENs) and caregiver only (link # 1.3.12.3).

Eye drops were dated when opened and currently in date.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked office in the rest home and each of the dementia units. Controlled drugs are stored in a locked safe in the rest home and two medication competent persons must sign controlled drugs out. The service uses four weekly blister packs medication management system. Medication charts have photo ID's. There is a signed agreement with the pharmacy.

Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet. This was a previous finding and all requirements have been met however, there are new findings identified.

**Finding:**

(i) Six monthly controlled drugs stock take are not completed. (ii) Six of 18 (one from the rest home, two from Grant Home and three from the hospital) medication charts have not been reviewed three monthly by the GP. (iii) Seven of 18 (one rest home, two Grant Home and four hospital) medication charts do not have indication for use for PRN medications documented by the GP. (iv) Oxygen has not been charted (one dementia and one hospital) and nitrolingual spray has not been charted (one hospital). This was discussed with the GP during the GP interview.

**Corrective Action:**

Ensure six monthly controlled drug stock take is undertaken. (ii) Ensure that the GP reviews the medication charts three monthly. (iii) Ensure PRN medications document indication for use. (iv) Ensure all medications are charted by the GP.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Registered nurses (RNs), enrolled nurses (ENs) and senior caregivers administer medicines. There are two ENs, 15 caregivers and all RNs administering medicines. Education on medication management occurred in March 2014 for enrolled nurses (ENs) and caregiver only.

**Finding:**

All staff that administer medicines do not have current medication competency assessments. Interview with the nurse manager and the Eldercare manager confirms education in medication management has not been provided for RN and staff that administer medicines have not been assessed to be competent in 2013 and 2014. RN medication competency assessments have not been conducted by the organisation since 2010.

**Corrective Action:**

Ensure all staff that administer medicines have current medication competency assessments.

**Timeframe (days):** 90 (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:** PA Moderate

**Evidence:**

One hospital resident and one rest home resident were self-administering medications. Policy on self-administering of medicines is documented.

**Finding:**

One hospital resident and one rest home resident do not have competency assessment completed to self-administer medications. Interview with the hospital resident evidences that the resident was confused when to take inhalers. Staff had signed for inhaler that was not taken until the auditor was present. Interview with the rest home resident evidences that the resident was not clear on when to take the eye drops.

**Corrective Action:**

Ensure that competency assessments are completed for residents self-administering medications.

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

The Croft has a commercial kitchen and all food is cooked on site by a contracted team. There is a team of twenty contracted staff. A food services manager with 22 experience, oversees the kitchen staff including two cooks and a kitchen hand during the day. The two cooks have level three certification in cooking and all kitchen staff have food handling training.

D19.2: There is a four weekly rotating menu with seasonable vegetables. The menu was last reviewed by a dietitian in April 2011. Food safety inspection by Verification New Zealand is current, dated 13 May 2013.

A food services manual is available and ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the older person, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet, sighted. The walk in freezer has twice-daily temperature recording, sighted. Food temperatures are recorded daily. Food is served directly from a bain marie in each of the three areas. Meals delivered to resident's rooms are served on a warming plate with a thermal cover to keep the food warm. All food in the freezer and fridge is labelled or dated.

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes (link # 1.3.4.2). This is reviewed six monthly as part of the care plan review (link # 1.3.8.3). Changes to residents' dietary needs are communicated to the kitchen as reported by the food services manager interviewed. Forms completed by the registered nurses to the food services manager were sighted for residents requiring fortified diets. The food services manager reports fortified diets include extra butter, double cream, extra ice-cream and other ways to make meals high fat and high calorie. Special diets are noted on the kitchen notice board, which can be viewed only by staff. Special diets being catered for include pureed diets and soft diets. There are folders of special dietary requirements available in each of the dining rooms for the staff to view when serving meals. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.

#### **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.

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Interview with management confirms there have not been any alteration to building since last audit.  
There is current building warrant of fitness (BWOFF) dated 1 June 2014.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service currently has no residents assessed as requiring restraints or enablers. Restraint education was last provided during the staff education day in February 2013 (17 staff attended). Interview with the restraint coordinator (eldercare manager, RN) was conducted and confirms restraint is discussed at quality meetings.

### 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

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control policies and procedures manual details surveillance processes. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

Infection logs are maintained and numbers of infections are collated at the end of each month and reported as a clinical indicator to management and staff. Clinical staff interviewed report they are made aware of any infections of individual residents by way of feedback from registered nurses and handovers.

The infection control coordinator (ICC) is responsible for surveillance within the service and oversees the infection control for the organisation. Interview with the infection control coordinator (RN) confirms surveillance data is collected, analysed and benchmarked.

#### 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.

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