# Presbyterian Support Southland - Resthaven Village

## Current Status: 23 April 2014

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

## General overview

Resthaven is part of the Presbyterian Support Southland (PSS) service. The service provides rest home, hospital, dementia and psychogeriatric level care services for up to 60 residents. On the days of the audit there were 51 residents – 19 rest home including one respite resident, 22 hospital residents, and six dementia and four psychogeriatric residents in a 10 bed secure unit.

Presbyterian Support Southland has an organisational structure that supports the continuity of management and quality of care and support.

The nurse manager at Resthaven has been in the role since July 2013 and is supported by the PSS director of older person’s services, a quality manager and the chief executive officer (CEO).

The service has addressed 10 of 13 shortfalls from the previous certification audit around: completion of the complaints register, discussion of quality information at various meetings, timely signing of admission agreements, timeframes of completion of aspects of care planning, follow up of resident’s test results and progress notes writing, evaluation of care plans, use of short term care plans, kitchen staff to be trained in safe food handling, quality review of restraint, and infection control training for staff.

Further improvements continue to be required around resident meeting minutes, development and completion of corrective actions, and one aspect of medication management.

This surveillance audit identified improvements are required around provision of 24 hour registered nurse cover in the dementia/psychogeriatric unit, recording of all interventions required for assessed needs, calibration and servicing of scales and hoists.

## Audit Summary as at 23 April 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 23 April 2014

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

### Organisational Management as at 23 April 2014

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 23 April 2014

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

### Safe and Appropriate Environment as at 23 April 2014

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 23 April 2014

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

### Infection Prevention and Control as at 23 April 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Presbyterian Support Southland |
| **Certificate name:** | Presbyterian Support Southland - Resthaven Village |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Resthaven Village |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services, including psychogeriatric; Rest home care including dementia care |
| **Dates of audit:** | **Start date:** | 23 April 2014 | **End date:** | 24 April 2014 |

|  |
| --- |
| **Proposed changes to current services (if any):** |
|  |

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 51 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 12 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 11 | Total audit hours | 35 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 11 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 90 | Number of relatives interviewed | 7 |
| Number of residents’ records reviewed using tracer methodology | 4 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Friday, 6 June 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Resthaven is part of the Presbyterian Support Southland (PSS) service. The service provides rest home, hospital, dementia and psychogeriatric level care services for up to 60 residents. On the days of the audit there were 51 residents – 19 rest home including one respite resident, 22 hospital residents, and six dementia and four psychogeriatric residents in a 10 bed secure unit. Presbyterian Support Southland has an organisational structure that supports the continuity of management and quality of care and support.The nurse manager at Resthaven has been in the role since July 2013 and is supported by the PSS director of older person’s services, a quality manager and the chief executive officer (CEO). The service has addressed 10 of 13 shortfalls from the previous certification audit around: completion of the complaints register, discussion of quality information at various meetings, timely signing of admission agreements, timeframes of completion of aspects of care planning, follow up of resident’s test results and progress notes writing, evaluation of care plans, use of short term care plans, kitchen staff to be trained in safe food handling, quality review of restraint, and infection control training for staff.Further improvements continue to be required around resident meeting minutes, development and completion of corrective actions, and one aspect of medication management.This surveillance audit identified improvements are required around provision of 24 hour registered nurse cover in the dementia/psychogeriatric unit, recording of all interventions required for assessed needs, calibration and servicing of scales and hoists. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| Open disclosure is inherent in the day-to-day operations of the service. Families report that they are always informed when their family member's health status changes or of any other issues or adverse events arising.Complaints processes are implemented; complaints and concerns are actively managed and well documented. Previous shortfalls have been addressed and monitored by the service relating to maintaining a complaints register.  |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| PSS Resthaven has an established quality and risk management system in place. Key components of the quality management system link to relevant meetings. The service is active in analysing data with evidence of benchmarking outcomes with other similar aged care facilities. Improvements are required relating to ensuring that corrective actions are recorded and implemented following all audits and meetings. Resident meetings are held. Improvement continues to be required in relation to the recording of detailed minutes to identify issues and areas for improvements. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels in the rest home and hospital areas provide sufficient and appropriate coverage for the effective delivery of care and support. Improvements are required whereby a registered nurse is rostered on duty in Oban dementia/psychogeriatric unit for each shift.  |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing care plans. The service has addressed and monitored previous findings relating to signing of admission agreements, completing assessments and care plans within required time frames, care plan evaluations and use of short term care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Improvements are required with updating interventions following review of the care plan. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to the use of assessment tools. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration receive training. Improvements are required for recording of allergies on the residents medication chart. Resident medications are reviewed by the residents’ general practitioner at least three monthly. Controlled drugs are appropriately stored and managed. The service has addressed and monitored previous audit findings. Self-medicating residents are appropriately supported to do so with three monthly competencies completed. The service has made improvements in this area. A range of activities are available in the rest home and residents provide feedback on the programme. Resthaven has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Kitchen staff have completed food safety training, this is an improvement from previous audit. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility is purpose built. All building and plant have been built to comply with legislation. The service displays a current building warrant of fitness. Improvements continue to be required in relation to calibration and servicing of scales and hoists.  |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. There are 11 residents currently on the restraint register assessed as requiring a restraint (bedrails and lap belts) and four residents with enablers (bedrails and lap belts). Policy states that the use of enablers is voluntary, requested by the resident. Restraint/enabler minimisation and challenging behaviour education has been provided.  |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The infection control nurse completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained, improvements have been made in this area. All infections are recorded as per standard definitions of infections on a monthly summary. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 15 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 3 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 57 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The resident file/care plan audit was conducted in December 2013 however, no corrective actions were developed following this quality activity. Non-compliance in some areas had been identified. Resident meetings take place on a monthly basis, however, no record of corrective actions or quality improvements made following these meetings are documented. | Document and implement corrective actions identified through all quality activities e.g. audits and residents meetings. | 90 |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability  | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.8.1 | There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Registered nurse cover in the Oban unit – dementia/psychogeriatric, does not meet contractual requirements as per ARHSS D17.3. There is a registered nurse on duty Monday to Friday from 0700 -1600. Outside of these hours, RN cover is provided by either the clinical team leader or the RN on duty from the rest home or hospital unit. | Ensure that residents assessed as requiring psychogeriatric level of care are receiving 24/7 registered nursing contact hours as per contractual requirements.  | 30 |
| 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 | The following shortfalls have been identified in the resident files reviewed; (i) pain assessments not conducted for two hospital residents and one rest home resident. (ii) nutrition assessment not conducted for one hospital resident and one rest home resident. (iii) challenging behaviour assessments not completed for one rest home resident with behaviours that challenge. (iv) weight issues not recorded for one rest home dementia resident and one rest home resident in the long term care plan. (v) no detailed behaviour management documented in the long term care plan for one rest home dementia resident and one hospital dementia resident. (vi) following evaluation of the long term care plan the intervention section is not always updated. (vii) wound assessments lack detail, plans lack timeframes and evaluation. | (i), (ii) and (iii) ensure that all risk assessments for residents are completed. (iv) and (v) ensure that all identified health issues are documented in the resident’s long term care plan. (vi) ensure that evaluation of the resident long term care plan is updated in the interventions. (vii) ensure that all wounds have a detailed management plan with frequency of wound dressing and evaluation. | 60 |
| 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 Low |  |  |  |
| 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 | Seven (two rest home, four hospital and one hospital dementia) of 12 of the medication charts did not have allergies or nil known allergies recorded on the individual medication chart. | Ensure that all residents’ individual medication charts have allergies or nil know allergies documented. | 30 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications  | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | Testing and tagging of electrical equipment is overdue – last conducted in December 2012. Calibration of scales and servicing and maintenance of standing and sling hoists throughout the facility has not been conducted since October 2012. Since the draft report the provider has stated that this was completed 29 May 2014. | Ensure all equipment is maintained and serviced regularly by an authorised technician. | 90 |

## **Continuous Improvement (CI) Report**

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

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Six residents (four rest home and two hospital) and seven family members (one rest home, three hospital, one dementia and two PG) report they were welcomed on entry and were given time and explanation about the services and procedures. Resident/relative meetings occur monthly. The nurse manager is readily accessible, confirmed in interviews with five care workers, three registered nurses, six residents and seven relatives. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is provided to residents on entry.D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.ARHSS: D16.4b The two family members interviewed state that they are always informed when their family member's health status changes or of any other issues arising. Evidence of open disclosure to the resident and relatives was verified in all accident/incident forms reviewed and in progress notes in five of five files reviewed. Progress notes in each resident file also records when families are contacted – following incidents, GP visits and medication changes. In relation to the Oban dementia/psychogeriatric unit, the information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new resident’s handbook providing practical information for residents and their families. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### Standard 1.1.13: 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:** |
| There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. Six residents (four rest home and two hospital) and seven relatives (one rest home, three hospital, one dementia and two PG) confirm they are aware of the complaints process and they would feel comfortable lodging a complaint or discussing concerns with the nurse manager if necessary.There is a complaints register that is up to date and includes relevant information regarding the complaint. Verbal complaints are included. A complaints folder is maintained. Advised by the nurse manager that all issues are recorded on the complaints register. There are five verbal complaints/suggestions lodged to date in 2014 and two written and 27 verbal complaints/suggestions/concerns lodged in 2013. All documentation relating to complaints and feedback including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder. The service has made improvements in this area. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Resthaven is part of the Presbyterian Support Southland services (PSS). PSS has four residential aged care homes under the services for older people, and also provides community services and Family works programmes. PSS has a very involved board which includes representatives from the community. The documented mission statement, states Presbyterian Support South Southland will “provide an environment where the right of older people to respect, privacy and dignity are valued. An environment where they can enjoy security, acceptance, and companionship”. The values of the service include respect, compassion, family, community and accountability. The service is managed by a nurse manager (registered nurse) who has been in this position since July 2013.There is a PSS wide organisational strategic plan for 2014. The board meets monthly. The nurse manager reports to the director of older persons services who in turn reports to the chief executive officer of PSS. Key strategic objective include providing a quality service, raising the profile of PSS, people, respecting the Treaty of Waitangi and ensuring organisational robustness. Resthaven provides rest home, hospital, dementia and psychogeriatric level care and support for up to 60 residents. On the days of audit there were 50 permanent residents and one hospital respite resident. There is a facility quality plan for 2014, and a quality planner. There are documented indicators and targets. Benchmarking occurs with other similar type facilities. The nurse manager is supported by the director of service for older persons and an organisational quality manager. The nurse manager attends more than eight hours annually of professional development relating to the management of an aged care environment. She has attended a leadership/motivational course, attends monthly management meetings and attends professional development in services at Resthaven.  |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a strategic plan for 2014 and a Resthaven quality improvement plan 2014 that are implemented. The quality system and internal audit programme is designed to monitor contractual and standards compliance and the quality of service delivery. The plan includes the visions, goals, critical success factors, strategies to achieve the goals and other initiatives. Quality goals include auditing and benchmarking, improving support plans, promote resident satisfaction and promote staff satisfaction. The vision for Resthaven is to provide a community where all can make the most of their strengths and feel valued, included and safe. The monthly and annual reviews of this programme reflect the service’s commitment to continuous quality improvement. Quality tools include audits, surveys, meetings, staff appraisals, clinical reviews, training, certification and benchmarking. Benchmarking is conducted via an Australasian benchmarking company who provide collation of data relating to complaints, satisfaction survey, skin tears, and falls, infections and staff work hours. The nurse manager is responsible of the implementation of the quality programme with support from the organisational quality manager. There is an internal audit schedule in place for Resthaven. There is evidence of the regular monitoring of a wide variety of aspects of the service via the internal audit schedule, the education planner and meeting planner. There is opportunity for each service under PSS to conduct quality improvement initiatives. Quality initiatives planned for 2014 include falls, infections and medication administration. Feedback and progress relating to quality and risk management systems is provided during staff meetings and monthly quality meetings. Monthly managers’ meetings are also held at PSS head office. The quality meeting and staff meeting agenda includes (but is not limited to) feedback pertaining to: internal audits; quality initiatives; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; education. Minutes are maintained and easily available to staff in the staff room (minutes sighted for March 2014 quality meeting and March 2014 staff meeting). Minutes include actions to achieve compliance where relevant. Discussions with three registered nurses, and five care workers confirm their involvement in the quality programme. The managers meeting held monthly is where benchmarking, facility reports and policy review is received. A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually. Internal audits schedule is in place for 2014. The completed audits for 2013 included personal hygiene, resident file and care plan audit, medication audit, cleaning, laundry, health and safety. Audits conducted for 2014 include restraint, call bells, admissions, infection control and cleaning, medications and staff uniform. Resident/relative meetings take place monthly – minutes sighted for April 2014. Discussion is held around activities, meals, gardens and resident cares. Previous certification audit identified that issues raised through resident meetings are not followed up and recorded. While hand written minutes are recorded following resident meetings, there is further improvement required around developing corrective actions to ensure all issues are addressed and followed through. D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. The reviews of the policies and procedures are scheduled to be completed on an annual basis and is discussed at management meetings held at head office.The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety meetings are held as part of the monthly quality meetings to discuss hazard management, falls and incidents, and hazard identification.There is a comprehensive infection control manual. There is a restraint policy and health and safety policies and procedures.There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.A document control system is in place. Documents no longer relevant to the service are removed and archived. Policies and procedures that are updated are documented on a document control sheet that is held in the front of each policy manual. The nurse manager reports staff are made aware of policy updates via staff meetings and copies of policy updates are posted in the staff room. Staff sign when they have read new or revised policies.The service collects information on resident incidents and accidents, and staff incidents/accidents. Incident/accident forms are completed and given to a registered nurse who completes the follow up. All incident/accident forms are seen by the nurse manager who completes any additional follow up and collates and analyses data to identify trends. Data is being benchmarked against other PSS aged care facilities and with QPS benchmarking service. Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through resident/relative meetings and surveys are followed up and actioned. Infection control data is collated monthly and reported to staff. One registered nurse, one care supervisor and two care workers interviewed are well informed about infection control. Data is being benchmarked against other aged care facilities.Actual and potential risks are identified and corrective actions initiated. There is a hazard register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually. Restraint/enabler use is reviewed and reported at the monthly CQI/management meeting at head office and at the three monthly restraint meetings. Results of internal audits, reports from incidents and accidents, infection rates, restraint use and health and safety issues are discussed with staff through the monthly staff meetings. This meeting incorporates discussion around health and safety, resident issues, infection control, education and quality assurance. Staff are able to contribute to the staff meeting agenda and a communication book also records outcomes of audits, and infection rates. The outcomes of audits, infection rates and falls incidence are displayed on the staff room notice board. A registered/enrolled nurses meetings is also held monthly to discuss a range of clinical issues, audits, incidents and accidents and clinical management (minutes sighted for March 2014). The service has addressed and monitored this previous finding.Corrective actions are documented following identification of shortfalls in care and service following audits and meetings - with the exception of the resident file audit and resident meeting minutes. Improvements are required in this area. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored. Resident/relative meetings occur monthly. Annual resident satisfaction surveys and family satisfaction surveys are completed – last conducted December 2013 with results presented in March 2014. The survey attracted 21 resident surveys returns and 21 family survey returns. In relation to family responses, 92% agreed with the statement that they were satisfied with the overall quality of the service. Survey questions related to care and service from staff, activities programme, social environment, accommodation and living areas, comfort and surroundings, medical care, food, cleaning and laundry, and maintaining community contact. Any combined over all response with less than 90% has been highlighted and a post survey corrective action plan has been developed. Feedback was provided to residents in the April 2014 newsletter  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Corrective actions are documented following identification of shortfalls in care and service following internal audits, surveys, quality meetings, staff meetings, complaints and incidents and accidents. |
| **Finding:** |
| The resident file/care plan audit was conducted in December 2013 however; no corrective actions were developed following this quality activity. Non-compliance in some areas had been identified. Resident meetings take place on a monthly basis, however, no record of corrective actions or quality improvements made following these meetings are documented. |
| **Corrective Action:** |
| Document and implement corrective actions identified through all quality activities e.g. audits and residents meetings. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Discussions with the nurse manager and registered nurses confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications.D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents.The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident by the individual witnessing the event, with immediate action noted by the registered nurse on duty and any follow up action required. Minutes of the quality meetings, registered/enrolled nurse meetings and staff meetings reflect a discussion of incidents/accidents and actions taken. Monthly reports are collated by the manager. Adverse events reported include falls – with or without injury, skin tears, behaviours, bruising, medication errors, staff incidents and other. Fourteen completed incident/accident forms were randomly selected for review from March 2014 and involved three staff related medication errors, and five residents – one dementia resident, one PG, two rest home and one hospital. All forms evidenced completion, medical and nursing follow up and changes to care planning if required. Incidents included falls, skin tears, and challenging behaviours. Investigations are conducted by the registered nurse. Either the clinical team leader or manager signs the forms when the investigation is completed. Accident and incident forms, and records in the medical/nursing summary provide evidence that families are kept informed - and confirmed on family interviews. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| PSS Resthaven employs 90 permanent and casual staff who work a mixture of part and full time. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity.A copy of practising certificates including registered nurses and general practitioners is kept. Current practising certificates were sighted for all registered health professionals - registered nurses, GP and dietitian.There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (one clinical team leader, one registered nurse, one new graduate registered nurse, one kitchen hand and four care workers from across all service levels). Reference checks are completed before employment is offered and are evident in staff files reviewed. Police vetting is not routinely conducted. Signed employment contracts are held at the PSS head office in Invercargill. Annual performance appraisals have been completed.  The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. One newly employed registered nurse was able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the nurse manager for staff who require additional training. Orientation programmes are specific to the service type (e.g. RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all eight staff files audited). PSS conducts a compulsory study days which all staff much attend every two years. Topics include culture and values of PSS, elder abuse, quality improvement, restraint minimisation, completing incident forms, documentation and privacy, infection control, Treaty of Waitangi and caring for the older person. Head office staff maintain records for staff attendance at the compulsory study day which staff must attend every two years. Discussion with the nurse manager, three registered nurses, and five care workers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed education plan for 2013 and a plan in place for 2014. The annual training programme exceeds eight hours annually. Additionally, all care workers are required to undertake aged care education within three months of commencement of employment. Five care workers interviewed have all completed the National Certificate in care of the elderly. The registered nurses are able to attend external training including conferences, seminars and sessions provided by Southland District Health Board (SDHB). In the Oban unit (dementia/psychogeriatric) there are 11 care workers employed – eight have completed the required dementia unit standards, and three have yet to start (commenced employment within the past six months). Education provided in 2013 included medication training, emergency care, fire drill, cultural safety, infection control, advanced care planning, and diabetes. First Aid training for staff has been provided. Education conducted in 2014 includes emergency care, manual handling, chemical safety, food safety and wound care. Efforts are undertaken by the nurse manager to ensure in-service education is regularly attended by staff (evidenced in interviews with the nurse manager, registered nurses, and care workers). Education records are maintained and are up to date. The nurse manager maintains comprehensive staff records to identify training needs and attendance.  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home and hospital units. Improvements are required in relation to registered nursing hours provided in the Oban unit – dementia/psychogeriatric in order to meet ARHSS contractual requirements. Interviews with three registered nurses, five care workers, six residents (four rest home and two hospital) and seven family members (one rest home, three hospital, one dementia and two PG) identify that staffing is adequate to meet the needs of residents. The nurse manager works full-time Monday-Friday and there is a clinical team leader (registered nurse) who works Monday to Friday across the rest home and hospital. In addition there is a registered nurse on duty 24/7 in the hospital unit, either a registered nurse or enrolled nurse on duty in the rest home unit on morning duty and a registered nurse on duty in Oban unit on morning duty – Monday to Friday. A physiotherapist is contracted to provide services for four hours per week and a therapy aide works three days per week.The roster includes a mixture of care workers working short and long shifts on am and pm shifts. Overnight there is one registered nurse on and three care workers – one in each unit. Three activities coordinators are employed – one the Oban unit and two in the rest home and hospital areas. The activities programme in Oban unit is provided for two days week by a diversional therapist. Care staff provide activities at other times and there is a weekly plan which care workers adhere to. Sufficient resources are available and care workers can access therapies for use at any time of the day or night if required. There are designated cleaning, kitchen and laundry staff employed. There is a full time cook Monday to Friday with weekend cooks and kitchen hands. The nurse manager reports staff numbers are adjusted based on resident acuity and the occupancy rate. |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home and hospital units. The nurse manager works full-time Monday-Friday and there is a clinical team leader (registered nurse) who works Monday to Friday across the rest home and hospital. In addition there is a registered nurse on duty 24/7 in the hospital unit, and either a registered nurse or enrolled nurse on duty in the rest home unit on morning duty. In the Oban unit (dementia/psychogeriatric) there is a registered nurse rostered on morning duty – Monday to Friday. A physiotherapist is contracted to provide services for four hours per week and a therapy aide works three days per week. |
| **Finding:** |
| Registered nurse cover in the Oban unit – dementia/psychogeriatric, does not meet contractual requirements as per ARHSS D17.3. There is a registered nurse on duty Monday to Friday from 0700 -1600. Outside of these hours, RN cover is provided by either the clinical team leader or the RN on duty from the rest home or hospital unit. |
| **Corrective Action:** |
| Ensure that residents assessed as requiring psychogeriatric level of care are receiving 24/7 registered nursing contact hours as per contractual requirements.  |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous certification audit identified that admission agreements were not signed on the day of admission. Informed consent forms are part of the admission agreement. In six of six files reviewed, admission agreements have been signed by either the resident or their representative on the day of admission and by a facility representative. The service has addressed and monitored this previous finding. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy that describe resident’s admission and assessment procedures. Registered nurses undertake the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission and the long term care plan is developed within three weeks of admission. This was a previous certification audit finding that is now being addressed and monitored. In all resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Six monthly reviews are conducted or earlier if resident health changes are completed by the registered nurse with input from the care staff, the activities coordinator and any other relevant person. Activities assessments and care plans are developed by the activities coordinator. Handover occurs at the end of each duty that maintains a continuity of service delivery. There is a communication book which staff read that includes reviewed policies. Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of six (two rest home, two hospital, one dementia and one psychogeriatric) residents files sampled. This was a previous certification audit finding that is now being monitored and addressed. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. GP interviewed stated that the service contacted her in a timely fashion, providing her with information required to assess her residents. The service always carried out any observations and interventions she prescribed. There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment f) behaviour assessment. This is an area that requires improvement and this was also a finding from the previous certification audit. Long term care plans reviewed for six residents’ evidence comprehensive and resident focused goals and interventions. This is an area that requires improvement. All six files identified integration of allied health including podiatry and older person’s health. Six resident files were sampled. Tracer methodology rest home: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*Tracer methodology hospital; XXXXXX *This information has been deleted as it is specific to the health care of a resident.* Tracer methodology rest home dementia: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*Tracer methodology psychogeriatric: XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Resthaven provides services for residents requiring rest home, hospital, dementia and psychogeriatric level of care. Dementia and psychogeriatric (PG) residents are accommodated in a combined unit (Oban). This is a 10 bed unit which currently has six dementia residents and four PG residents. The facility has an unwritten agreement to provide these services in this manner. The two service types are not segregated. Activities and diversional therapies are designed and provided specific to the cohort of residents in this unit. Advised that if any residents develop behaviours that impact on other residents, then reassessment or alternative placement is sought. Advised that there are currently no residents in the Oban unit whose behaviours impact adversely on others or that cannot be managed by care staff and registered nursing input. Individualized care plans are completed. The five care workers and three registered nurses interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There are currently seven wounds being treated and no pressure injuries. Wound assessment and treatment is completed for wounds and there was evidence of referral to wound and vascular specialists and wound care district nurses. Detailed management plans with frequency of wound dressings and evaluation is an area that requires improvement. Wound care education was provided in March 2014. Six residents (four rest home and two hospital) and seven family members (one rest home, three hospital, one dementia and two psychogeriatric) interviewed confirm their current care and treatments they and their family members are receiving meet their needs. Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed. All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required. A physiotherapist aide is available three days per week. There are registered nurses on duty 24/7 in the hospital unit, registered nurse on duty in the dementia/psychogeriatric unit Monday to Friday on morning shift (link #1.2.8.1) and the manager is a registered nurse. A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. On review of six resident files, four files evidenced that pain, nutrition and challenging behaviours are not completed when required. This is an area that requires improvement. Care plans are goal orientated and reviewed at six monthly intervals. Care plans are not always updated to reflect intervention changes following review or change in health status. This is an area that requires improvement and this was a previous certification audit finding. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.  |

##### **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:** |
| Resthaven provides services for residents requiring rest home, hospital, dementia and psychogeriatric care level of care. Individualized care plans are completed. The five care workers and three registered nurses interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment. Calibration of equipment was evidenced as being overdue for service (#link 1.4.2).Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There is currently seven wounds being treated and no pressure injuries Needs are assessed using pre admission documentation; doctor’s notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status. |
| **Finding:** |
| The following shortfalls have been identified in the resident files reviewed; (i) pain assessments not conducted for two hospital residents and one rest home resident. (ii) nutrition assessment not conducted for one hospital resident and one rest home resident. (iii) challenging behaviour assessments not completed for one rest home resident with behaviours that challenge. (iv) weight issues not recorded for one rest home dementia resident and one rest home resident in the long term care plan. (v) no detailed behaviour management documented in the long term care plan for one rest home dementia resident and one hospital dementia resident. (vi) following evaluation of the long term care plan the intervention section is not always updated. (vii) wound assessments lack detail, plans lack timeframes and evaluation. |
| **Corrective Action:** |
| (i), (ii) and (iii) ensure that all risk assessments for residents are completed. (iv) and (v) ensure that all identified health issues are documented in the resident’s long term care plan. (vi) ensure that evaluation of the resident long term care plan is updated in the interventions. (vii) ensure that all wounds have a detailed management plan with frequency of wound dressing and evaluation. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are three activities coordinators at Resthaven who are responsible for the planning and delivery of the activities programme. One activities coordinator has been employed at Resthaven for over eight years with two years in activities. This staff member has NZQA qualifications in aged care including dementia care and works five days per week, six and a half hours per day. Another activities coordinator works part time including Fridays and Mondays with another extra day on a two weekly roster. There is a diversional therapist (DT) as part of the team that works in the dementia/psychogeriatric unit for 10 hours per week over two days. The activity staff have a roster for working Saturdays. The rest home and hospital activities are combined. The DT is responsible for planning the programme in the dementia/psychogeriatric (Oban) wing. The DT has been employed at Resthaven for six months and has a qualification in diversional therapy with over eight years’ experience. Prior to working at Resthaven the DT worked with special need adults. Activities staff at Resthaven meet regularly with other activities coordinators in the area to share ideas. The DT is also part of the area diversional therapy group and attends conferences. Care workers deliver the programme in the dementia wing when the DT is not on duty. Advised by the DT that the programme is planned and there are resources and programmes for care workers to follow. There are sufficient resources to provide diversional therapy and activities in the Oban unit when the DT is not on duty. One caregiver was previously the DT at Resthaven. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident’s rooms when required. The Oban unit has a secure outdoor area that residents access and remain safe. On the day of audit residents were observed being actively involved with a variety of activities. There is a regular fixed programme that is available in the resident’s room with additional weekly extra activities displayed on the lounge notice board. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events. An activities care plan is developed within three – four weeks after admission. The resident/family/EPOA as appropriate is involved in the development of the activity plan. This is evaluated six monthly or earlier as required. The evaluations were accommodating of the residents current health status. A record is kept of individual resident’s activities and monthly progress notes completed. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. The programme includes residents being involved within the community with social clubs, churches and schools and visits to other aged care facilities.Resthaven has its own van for transportation. Residents interviewed described weekly outings, crafts and baking. They enjoy the wide range of activities. The dementia wing also has outings with appropriate staff management for safety. D16.5d: Resident files reviewed identified that the individual activity plan is reviewed at care plan review.  |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| All initial care plans were developed by a registered nurse on day of admission and resident comprehensive long term care plans developed within three weeks of admission. Long term care plans are evaluated six monthly or if there is a change in health status. Updating of the interventions following evaluation is an area that requires improvement as per #1.3.6.1. There was documented evidence that care plan evaluations were up to date in all six resident files sampled. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by a RN. GP's review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out her instructions, giving her full confidence in the management of the residents. Short term care plans were evident for current and previous wounds, skin tears, urinary tract infections and return from acute care. This was an area for improvement from the previous certification audit and is now being addressed and monitored.  |

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

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

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

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

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

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

#### Standard 1.3.12: 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 Low |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, with three monthly reviews of medication occurring by GP. Five of 12 medication charts (two rest home, two rest home dementia and one hospital dementia) had allergies recorded. This is an area that requires improvement. Resthaven uses the Robotic System of two weekly packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents’ general practitioners; these are kept in the medication folders. The medication folder includes a list of specimen signatures. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. 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 October 2013 with competencies conducted for registered nurses and senior caregivers with medication administration responsibilities. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and PRN medication. Advised that caregiver administering medications check with the RN prior to administrating PRN medication. This was a previous finding that is now being addressed and monitored. The service has adequate information and supervises the self-administration of medicines. Advised that self-administered medications would be securely stored in locked drawers in the resident’s room. One resident was self- administrating medications. The medications were safely locked away in the resident’s rooms. Policy states that the resident’s wishing to self-medicate must be assessed for competency three monthly. Competency for self- administration for this resident was last completed on 26 February 2014 by the GP with an entry in the progress notes and on the self-administration competency assessment form. The service has addressed and monitored this previous finding. The service has in place and has implemented systems to ensure, a) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and b) adverse reactions and administration errors are recorded. There is a staff signature identification sheet in the front of the medication folders. Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.Medications were safely stored in the rest home and hospital units on two trolleys which were kept in a locked in the treatment room. Medications are stored in a locked cupboard in the locked nurses’ station in Oban (dementia/psychogeriatric) unit and brought out at administration times. There is no controlled drug cupboard in the Oban wing. Fridge temperatures are monitored and sighted (two). This was a previous certification audit which has now been addressed. No stores of medications were kept in the dementia wing. All medications were up to date and eye drops were dated on opening. The controlled drug register showed evidence of weekly and six monthly checks. This was a previous certification audit finding that has now been addressed. The register showed evidence of two when signing out controlled drugs. Three registered nurses and one caregiver were observed safely administration medications at the breakfast and the lunch time medication round. Two registered nurses were observed safely administrating controlled drugs. |

##### **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:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, with three monthly reviews of medication occurring by GP. Five medication charts (two rest home, two rest home dementia and one hospital dementia) had allergies recorded.  |
| **Finding:** |
| Seven (two rest home, four hospital and one hospital dementia) of 12 of the medication charts did not have allergies or nil known allergies recorded on the individual medication chart. |
| **Corrective Action:** |
| Ensure that all residents’ individual medication charts have allergies or nil know allergies documented. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Resthaven has a commercial kitchen and all food is cooked on site. There is one main cook and two relief cooks. They all cover the weekends. The main cook has been employed at Resthaven for thirteen years and has unit standards 167 and 168 qualifications including hazard training. There are four tea time and four day time kitchen hands and all have completed food safety training. This was a previous certification audit finding that has now been addressed. There is a four weekly rotating menu for spring/autumn and summer/winter. The menu has been approved by a dietitian. A food services manual is available that 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 elderly, 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. Food temperatures are recorded daily. There are three dining areas. Food is served to the rest home directly from the Bane Marie in the main kitchen. Another Bane Marie is used to serve the meals to the resident in the hospital dining room. The meals for residents in the dementia wing is served from the main kitchen and transferred to the dementia wing on a trolley. The food is covered with thermal covers to keep the food hot and served directly to the residents. All food in the freezer and fridge is labelled or dated. All food in the pantry is on shelves and decanted food dated and labelled.The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook interviewed. There is also a white board in the kitchen for any new dietary changes. Forms from the registered nurse to the cook were sighted for residents requiring fortified diets. The cook 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 in a file in the kitchen, which can be viewed only by kitchen staff. Special diets being catered for include pureed diets and soft diets. The main cook has two days when she does home baking and orders the food. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Relatives interviewed report that their relatives are very happy with the meals. There is homemade baking for morning and afternoon tea. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks |

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

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

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

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

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

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

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

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

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

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

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

#### Standard 1.4.2: 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:** PA Low |
| **Evidence:** |
| The service displays a current building warrant of fitness which expires on 24 June 2014. Previous certification audit identified that scales had not been calibrated (previous finding #1.3.3.4). On a tour of the facility it was noted that scales and hoists were overdue for service and calibration, and testing and tagging of electrical equipment was due in December 2013. Improvements continue to be required in this area.  |

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

All buildings, plant, and equipment comply with legislation.

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Building warrant of fitness expires on 24 June 2014. The facility is purpose built and there is a comprehensive maintenance programme implemented by a maintenance person. |
| **Finding:** |
| Testing and tagging of electrical equipment is overdue – last conducted in December 2012. Calibration of scales and servicing and maintenance of standing and sling hoists throughout the facility has not been conducted since October 2012. Since the draft report the provider has stated that this was completed 29 May 2014. |
| **Corrective Action:** |
| Ensure all equipment is maintained and serviced regularly by an authorised technician. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint minimisation is overseen by a restraint coordinator (nurse manager). There are 11 residents currently on the restraint register assessed as requiring a restraint (bedrails and lap belts) and four residents with enablers (bedrails and lap belts). The residents with restraint include one psychogeriatric resident with bed rails and a lap belt, two dementia residents with lap belts, five hospital residents with bed rails, two hospital residents with bedrails and lap belt, and one rest home resident with bed rails. The residents with enablers are all hospital level residents and include two residents with bed rails, one resident with a lap belt, and one resident with bedrails and a lap belt. Three resident files reviewed – two restraint and one enabler, evidence completion of assessments, consent, restraint care planning, monitoring and three monthly evaluations. Policy states that the use of enablers is voluntary, requested by the resident. Restraint/enabler minimisation and challenging behaviour education has been provided. Restraint/enabler training and challenging behaviour training is included in the compulsory study day which all staff must attend every two years. Staff complete a questionnaire/competency on restraint minimisation and safe practice.  |

##### **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.)* |

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint coordinator is responsible for ensuring restraint use is actively minimised, monitored and reviewed for each episode of restraint use. Review of restraint use and associate programme is conducted at the three monthly restraint review meetings (last conducted 25 February 2014). A monthly report is developed on the number and type of restraints in use. Review of restraint policies and procedures is conducted at organisational level via the monthly management meetings. Audits are conducted regarding restraint use (27 February 2014) and this was discussed at the following quality meeting (minutes sighted). Episodes of restraint use, trends and progress made in minimising restraint are reviewed to ensure the restraint is only used when necessary, appropriate and safe. Individual resident reviews are conducted three monthly. The service has addressed and monitored this previous finding. |

##### **Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

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

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

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous certification finding relating to infection control coordinator training not been provided has been addressed and monitored. Refer #3.4. |

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous certification audit identified that there was no evidence of infection control training at Resthaven on an on-going basis (#3.4.2). The clinical team leader (registered nurse) is the infection control coordinator at Resthaven. This staff member was unavailable on the days of audit. On review of education records it is noted that education relating to infection control has been provided in March 2013 with associated evaluation of the session. A comprehensive infection control questionnaire was also completed by all staff- clinical and non-clinical, in January 2014 and marked by the infection control coordinator. All staff are required to attend a compulsory study day every two years. Topics provided include infection control training. Hand hygiene and infection prevention and control are also included in the orientation of new staff. The infection control coordinator has completed training relating to infection prevention and control in 2013. The service has addressed and monitored this previous finding.  |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance is an integral part of the infection control programme and is described in PSS Resthaven’s infection control policy. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical team leader) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service.The service utilises benchmarking within PSS facilities and programmes on a quarterly basis. Systems in place are appropriate to the size and complexity of the facilityInfection surveillance is an integral part of the infection control programme and is described in the infection control policy.Monthly infection data is collected for all infections. All infections are entered on to an infection register. This data is monitored and evaluated. Outcomes and actions are discussed at the monthly staff meetings, monthly registered/enrolled nurse meetings, monthly quality meetings and PSS management meetings. Emergent issues are discussed at handover, recorded in the communication book and information and data is displayed on the staff notice board. |

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

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

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

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

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

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