# Christchurch Methodist Central Mission

## Current Status: 1 May 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

WesleyCare Home and Hospital is owned and operated by the Christchurch Methodist Central Mission. The WesleyCare home is a four level building with two floors for rest home residents and one for hospital. The facility manager has been in the role for over 24 years and reports to the Methodist Mission board. The manager is also supported by a quality coordinator, clinical nurse managers, registered nurses and care staff. The home and hospital is certified to provide hospital, medical and rest home level care for up to 108 residents.

Staff interviewed and documentation reviewed identified that the service has made improvements to the quality and risk management programme and continues to provide services that meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided and advised that the staff are caring and attentive. The Mission has commenced a rebuild project to replace the current facility. The building site is adjacent to the existing structures with health and safety risks appropriately managed.

The service has addressed 11 of the16 shortfalls from the previous certification audit relating to ensuring all residents have signed agreements in place, clinical policies, reference checks, contract time frames, hot water temperatures, first aid training, restraint monitoring, timely review of restraint use, infection policies reflect current best practice and infection surveillance captures all infections.

Further improvements continue to be required around utilising a range of assessment tools, care plan interventions, short term care plans, wound care documentation, and aspects of medication management. This audit identified an improvement also required in relation to food, fridge and freezer temperature monitoring.

## Audit Summary as at 1 May 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 1 May 2014

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| 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 1 May 2014

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 1 May 2014

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| 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 1 May 2014

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

### Restraint Minimisation and Safe Practice as at 1 May 2014

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

### Infection Prevention and Control as at 1 May 2014

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| 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**

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| --- | --- |
| **Legal entity name:** | Christchurch Methodist Central Mission |
| **Certificate name:** | Christchurch Methodist Central Mission |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Wesley Rest Home and Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 1 May 2014 | **End date:** | 2 May 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 83 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **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**

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

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 20 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 100 | Number of relatives interviewed | 7 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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| --- | --- | --- |
| 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 Monday, 16 June 2014

## **Executive Summary of Audit**

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| **General Overview** |
| WesleyCare Home and Hospital is owned and operated by the Christchurch Methodist Central Mission. The WesleyCare home is a four level building with two floors for rest home residents and one for hospital. The facility manager has been in the role for over 24 years and reports to the Methodist Mission board. The manager is also supported by a quality coordinator, clinical nurse managers, registered nurses and care staff. The home and hospital is certified to provide hospital, medical and rest home level care for up to 108 residents. On the day of the audit there were 83 residents – 37 rest home and 46 hospital. Staff interviewed and documentation reviewed identified that the service has made improvements to the quality and risk management programme and continues to provide services that meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided and advised that the staff are caring and attentive. The Mission has commenced a rebuild project to replace the four level rest home/hospital facility. The building site is adjacent to the existing structures with health and safety risks appropriately managed. The service has addressed 11 of the16 shortfalls from the previous certification audit relating to ensuring all residents have signed agreements in place, clinical policies, reference checks, contract time frames, hot water temperatures, first aid training, restraint monitoring, timely review of restraint use, infection policies reflect current best practice and infection surveillance captures all infections.  Further improvements continue to be required around utilising a range of assessment tools, care plan interventions, short term care plans, wound care documentation, and aspects of medication management. This audit identified an improvement also required in relation to food, fridge and freezer temperature monitoring. |

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| **Outcome 1.1: Consumer Rights** |
| The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. Admission agreements are now in place for all residents. The service has addressed and monitored this previous finding. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are able to residents and family. Information relating to the Health and Disability Commissioner and advocacy service with contact details are also provided. Information on how to make a complaint and the complaints process are included in the admission booklet, complaints are actively managed. |

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| **Outcome 1.2: Organisational Management** |
| WesleyCare rest home and hospital has a current business and quality plan to support quality and risk management. The service has engaged the services of an experienced quality coordinator who has conducted a thorough review of policies, procedures and associated documents. The service has made improvements in this area. Quality information is gathered from internal audits, incidents and accidents, feedback from residents, family and staff. Data is collected and collated to provide opportunities for improvement. Corrective actions are implemented. Resident/relative surveys are undertaken annually. Adverse events are investigated and opportunities for improvement are actioned. Staff requirements are determined using a skill mix process and acuity levels and documented. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents. The service has a documented training plan. The service has addressed and monitored a previous finding relating to conducting reference checks for new staff. |

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| **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 nurse who also has the responsibility for maintaining and reviewing 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. There continues to be improvements required since the previous audit around assessments, and care plan interventions. The service has addressed the previous finding around care plan evaluations and contract timeframes. The medication management system includes policy and procedures that follows recognised standards. There is an improvement required around medication documentation and competencies. Resident medications are reviewed by the residents’ general practitioner at least three monthly. A range of activities are available in the rest home and residents provide feedback on the programme. WesleyCare rest home and hospital has food policies and procedures for food services and menu planning appropriate for this type of service. All kitchen staff have completed food safety training. 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, freezer and hot food temperatures monitoring and recording is an area requiring improvement. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| WesleyCare rest home and hospital provides services across two adjacent buildings. Both have a current building warrant of fitness certificate which expire on 1 January 2015. Hot water temperatures are monitored in both buildings and while the recorded temperatures are above the expected levels, the service advises that every effort has been made to rectify the problem. The DHB are aware of the issue. The new building scheduled for completion in October 2014 will eliminate this issue. First aid training has been provided for all registered nurses. The service has addressed this previous finding. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has five rest home residents with restraint, one with an enabler; 10 hospital residents assessed as requiring enablers and 13 hospital residents with restraint. Restraint includes the use of bedrails and lapbelts. There is a restraint register and an enabler register. Staff receive training in restraint minimisation and challenging behaviour management, competencies are also completed. The service has addressed and monitored the previous findings relating to monitoring of restraint and conducted three monthly restraint reviews. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control nurse (registered nurse) at WesleyCare rest home and hospital completes a monthly infection summary which is discussed at quality and staff meetings. The service has addressed and monitored the previous finding relating to infection control policies and procedures. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary and are based on signs and symptoms of infection. The service has made improvements in this area. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 19 | 0 | 1 | 4 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 3 | 3 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 26 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 54 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | (i)One rest home resident does not have a pain assessment; (ii) Two residents (one hospital and one rest home) do not have continence assessment; (iii) three residents (one hospital and two rest home) do not have nutrition assessment; (iv) one rest home resident does not have a challenging behaviour assessment. | (i) Ensure that all residents have a pain assessment on admission; (ii) Ensure that all residents have a continence assessment as required; (iii) Ensure that all residents have a nutritional assessment on admission; (iv) Ensure that all residents with identified challenging behaviour have a behavioural assessment completed. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | a) One hospital level palliative care resident did not have an initial care plan developed; b) long term care plans do not include all aspects of resident care requirements including activities of daily living. | a) Ensure all residents have an initial care plan developed to record the level of care and support required; b) ensure that the long term care plan includes and addresses all care requirements. | 60 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| 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 | (i) In two of the files sampled (hospital), interventions were not documented in care plans to address all current needs – in one hospital file sampled there was no documented evidence of a management plan for identified challenging behaviours; one resident had documented evidence of three falls in March 2014 with no evidence of interventions or goals for falls prevention. (ii) 17 of the 28 wound care plans did not show evidence of frequency of wound dressing or evaluation, two wounds did not show evidence of frequency of dressing, one wound had no documentation since 29 April 2014 and one wound had no treatment record since 9 April 2014, however there was a written evaluation on 29 April 2014; (iii) On review of a sample of incident reports (#1.2.4), it was noted that there were no short term care plans developed for three residents with documented skin tears, one resident with a documented medication error, one resident with a documented reddened area on the back/shoulder and one resident with a documented head injury including no documented evidence of neurological observations completed | (i) Ensure that care plans include all required interventions to address current health changes. (ii) Ensure that all wound care treatment has documented evidence of frequency of dressings, evaluations of the wound and appropriate/timely documentation; (iii) Ensure that all residents with acute issues have a short term care plan developed by the registered nurse or amendments are made to the long term care plan. | 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | (i) Five of eleven rest home residents individual eye drops were not dated on opening. (ii) Temperatures of medication fridges in the treatment room in the hospital third floor and in the treatment room in Marblewood hospital were not evidenced as being monitored or recorded. | (i) Ensure that all eye drops are dated on opening. (ii) Ensure that temperatures of the medication fridges in the hospital third floor treatment room and Marblewood treatment room are monitored and recorded daily. | 60 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Three registered nurse staff files reviewed evidenced that medication competency has not been maintained annually. | Ensure that all registered nurses have medication competency conducted annually. | 60 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | (i) Temperatures of fridges and freezers in Marblewood kitchen were not evidenced as recorded. (ii) hot food temperatures in both kitchens and kitchenettes are insufficiently monitored and recorded | (i) Ensure that temperatures of fridges and freezers in Marblewood hospital unit are monitored and recorded. (ii) Ensure that hot food is monitored and recorded in line with safe food practices. | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either health care assistants or the registered nurses and a copy of any incident relating to individual residents is included in the clinical file. A communication sheet records that families are informed following general practitioner (GP) review, incidents or accidents or if there is a change in resident condition (confirmed by seven relatives interviewed – five rest home and two hospital). Interviews with the nurse manager, two clinical nurse managers and four registered nurses all stated that they are to record contact with family/whanau in resident files. Incident forms have a section to indicate if family/whanau have been informed of an incident/accident.  Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in each resident’s file and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet.  Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet. Seven residents (three rest home and four hospital) and seven relatives (five rest home and two hospital) interviewed, confirmed they are kept fully informed. The admission booklet is available in large print and can be read to residents if required. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous certification audit identified that not all residents had a signed admission agreement in place. Previously, any resident admitted prior to 2011 did not have an admission agreement. Advised that signed admission agreements are now in place for all residents as evidenced in six clinical files reviewed and four restraint files reviewed. The admission agreement is a standardised agreement which covers all aspects of care and services provided. The service has made improvements in this area. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints process and forms for completion are available within the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. The manager maintains the records of all complaints that are processed as evidenced by the one complaint received in 2013 and one in 2014. Details of the management of the complaints is recorded including letters of follow up and response. Complaints are discussed at the monthly quality assurance meetings. A complaints procedure is provided to residents within the information pack at entry. Seven residents and seven family members interviewed were aware of the complaints process and advised that management is approachable and responsive to any issues or areas of concern. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Christchurch Methodist Central Mission owns and operates WesleyCare rest home and hospital. The manager is a registered nurse who maintains an annual practicing certificate. She is experienced in aged care and has been manager of WesleyCare rest home and hospital for over 24 years. The manager reports to the chief executive officer of the mission on a variety of areas relating to health and safety, quality, repairs and maintenance, wages, rostering and staffing, and occupancy. The mission has a strategic plan for 2009 – 2014 which includes provision of services to the elderly. There are documented goals and strategies in place for all aspects of the mission’s services. The strategic plan for WesleyCare includes goals around resident care, staffing and training, care planning, and human resource management. A quality management system is implemented which includes gathering data and information to provide opportunities for quality improvement. The organisation has a mission statement and documented philosophy of care: ‘care of the older person should be individualised and holistic focusing on retention of dignity and independence to maintain optimum health and wellbeing in an environment which is safe and homelike”. The manager has attended in excess of eight hours of professional development in the past 12 months relating to managing the facility and includes attending aged care conference, attending internal and external meetings, attending two monthly DHB aged care committee meetings and maintaining nursing professional development. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| WesleyCare rest home and hospital has a current quality management programme for 2013 - 2015 which includes the mission and philosophy of service, a quality policy statement and objectives. The quality programme objectives cover each service level including clinical, diversional therapy, household, and health and safety. A quality assurance committee meets monthly and includes representatives from all areas of the service and a resident representative. The quality management plan is reviewed annually (last conducted in January 2014 for 2013 year) and includes risk management, roles and responsibilities and human resource plan. Objectives for the programme includes (but not limited to): clinical records, medications, infections, waste management, building and equipment, financial, staffing, supplies, cleaning and laundry, resident care planning, incidents and accidents. The nurse manager and quality coordinator are responsible for the implementation of the quality programme. The risk management plan includes areas relating to: legal, operational, personnel, technology, political, natural disasters and financial. Hazard management for the facility includes health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.  Progress with the quality programme and risk management plan is monitored through the monthly quality assurance meetings, various staff meetings, and a comprehensive annual review is conducted. The annual review involves review of the diversional therapy programme, incident trend and analysis, complaints, corrective actions, infection control programme, service monitoring and service risk. A quality coordinator is contracted and attends the facility for two days per week to review progress. The monthly quality assurance meeting agenda includes (but is not limited to): previous meetings minutes, health and safety, staff incidents and accidents, education, resident incidents and accidents, infection control, annual quality objectives, policy and document review, audits, restraint, and complaints.  Minutes from the quality meetings are available for staff to read in the staff room (sighted for April 2014). Care staff interviewed (six health care assistants) advised that they have access to meeting minutes and sign when they have read them. Staff meetings are held separately for the home and hospital at least two monthly. All meeting minutes have a corrective action format and include actions to achieve compliance where relevant. This, together with staff training, demonstrates WesleyCare’s on-going commitment to continuous quality improvement. Discussions with registered nurses and health care assistants confirm their involvement in the quality programme. Folders in the nurse’s stations are maintained with meeting minutes, quality and audit outcomes. Resident/relative meetings take place three monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for February 2014. Other meetings include registered nurse meeting, restraint, health care assistants, and household staff meetings. There is an internal audit schedule completed for 2013 and a plan in place for 2014. It includes (but is not limited to): cleaning, resident files, laundry, medications, restraint monitoring, staff records, hazard monitoring and monthly health records. There is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. Corrective actions are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions.  The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.  The new building project currently underway has included the removal of three studio units in the hospital unit. This area is now boarded up and secure. Building has commenced for a new kitchen and chapel in one area and hospital/rest home unit in another area. These building sites are fenced off from residents, staff and visitors. Monthly meetings are held between the project manager, site manager, facility manager and CEO to discuss progress and health and safety. There is a risk management plan and hazard management plan in place. The service also conducts a health and safety audit of the building sites to monitor safety impact on residents, visitors and staff.  There is a new infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The service has policies/ procedures to support service delivery. The quality coordinator has reviewed and updated all clinical policies in the past six months with education and training provided to clinical staff. New or revised policies include introduction of new assessments for nutrition, challenging behaviours, pain, continence, falls risk and skin; short term care plan policy and forms; revised advanced directives and resuscitation forms. Education for clinical staff was conducted in February 2014 by the quality coordinator. All other policies have been reviewed in the past year (May 2013) and reflect current standards and contractual requirements. The service has addressed and monitored this previous finding. Further improvements are required to ensure that resident care plans align with the reviewed policies and procedures (link findings in 1.3.4.2, 1.3.6.1). The quality coordinator and manager are responsible for development and review of policies and procedures and these are then provided to the quality committee for sign off. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. There are procedures to guide staff in managing clinical and non-clinical emergencies and implemented risk management, health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, increased supervision and monitoring and sensor mats if required. The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by health care assistants and given to the registered nurses, who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the clinical manager and manager who completes any additional follow up. The manager collates and analyses data to identify trends. Results are discussed with staff through the monthly quality assurance meetings, and staff meetings.  A resident survey (2013) and a relative’s survey (2014) is conducted two-yearly. Residents and families are surveyed on staff, communication, privacy and dignity, respect and courtesy, values and beliefs, care planning, medical care, safety and security, food services, environment, laundry, activities and complaints process. The surveys reviewed evidence that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via meetings. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality assurance committee meetings, and at staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and seven family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incident forms for March 2014 were reviewed and involved eight residents – two rest home and six hospital. Incident reports related to falls, bruising, head injury, skin tears, wandering, and two medication errors. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by either the clinical nurse managers or facility manager. Referral to general practitioner, and needs assessment team has been instigated as required. A monthly incident trend analysis and annual incident trend analysis is conducted with reviews and summaries is compiled by the quality coordinator and manager with subsequent analysis and investigations. Analysis occurs around falls, skin tears, challenging behaviours, medication errors, bruising and wounds. Incidents and accidents are reported in progress notes and communication with family regarding incidents is also recorded. Staff have received education regarding open disclosure, incident reporting and communication with families. Improvements are required in relation to post incident response documentation – short term care plans and neurological observations (refer finding #1.3.6.1) |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses, and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (two clinical nurse managers, one registered nurse, one household supervisor, one casual service worker and one health care assistant). Advised that reference checks are completed before employment is offered as evidenced in two recently employed staff files reviewed. The service has addressed and monitored this previous finding. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Six health care assistants interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in six of six staff files reviewed.  Discussion with the manager, two clinical managers, four registered nurses, one enrolled nurse and six health care assistants confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and a plan for 2014 that is currently being implemented. The annual training programme exceeds eight hours annually. Care givers have completed either the national certificate in care of the elderly or are working towards completion. The manager, clinical managers and registered nursing staff attend external training including conferences, seminars and sessions provided by the local DHB.  Education provided in 2013 includes but not limited to: cultural safety, medications, manual handling, care plans, diabetes, wound management, continence and catheter care, challenging behaviours, infection control. Registered nurses (RN) complete syringe driver training and competencies two yearly (last conducted April 2014). Registered nurses and senior health care assistants complete medication training and competencies, however, this was noted to have lapsed for three RN files reviewed (link #1.3.12.3)  Fire evacuation drill last conducted on 12 December 2013. Annual appraisals are conducted for all staff as evidenced in five of six files reviewed (one employee commenced employment within the past 12 months). |

##### **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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Human resource management policies includes a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home and hospital residents. There is a registered nurse on duty 24/7 for the hospital residents on 3rd floor (hospital) of the rest home/hospital building and a registered nurse on duty in the adjacent hospital unit 24/7. In addition there are two clinical nurse managers employed – one in each building – who work Monday to Friday. The manager works full time. There is a minimum of one health care assistant on duty overnight in each level of the rest home/hospital building and in the hospital unit. Enrolled nurse’s and health care assistants work short and long shifts in each area. Staffing levels have been altered in response to the decrease in resident numbers due to the building project and planned shift into the new facilities. The service also employs laundry staff, cleaning staff, cook and kitchen hands and a maintenance person and gardeners. Interviews with the manager, two clinical nurse managers, four registered nurses, one enrolled nurse, six health care assistants, seven residents and seven family members identify that staffing is adequate to meet the needs of residents. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection identified that resident detail is kept private and this is an improvement on previous audit. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy and process that describes resident’s admission and assessment procedures. D16.2, 3, 4: Five (three hospital and two rest home) of six resident files sampled (four hospital and two rest home) identified that an initial nursing assessment and care plan was completed within 24 hours by the registered nurse (# link 1.3.6.1). Three of six files identify that the long term care plan was completed within three weeks by the registered nurse. This previous audit finding has now been addressed and monitored. Three of six care plans evidenced evaluations completed at least six monthly. Three residents (two hospital and one rest home) have not been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the diversional therapist or the activities coordinator.  Seven residents interviewed (three rest home and four hospital) stated that they or their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed in all resident files sampled. D16.5e: Six resident files reviewed identified that the GP had seen the resident within two working days. Three of the residents have been reviewed by the GP at least three monthly. Three residents (two hospital and one rest home) have not been at the service longer than three months.  Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Six files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the clinical managers and registered nurses consult with the GP with any concerns regarding residents’ health status and she believes the service provided meets resident’s needs.  Tracer Methodology hospital:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology rest home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Previous audit identified that the range of assessments tools were not utilised for all residents on admission or reviewed six monthly. Residents’ personal needs information is gathered during admission by the registered nurse. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans include input from a general practitioner, support services and medical specialists as appropriate. Of the six files sampled (two rest home and four hospital), there continues to be areas where assessment tools have not been conducted as per resident requirements. This remains an opportunity for improvement. The service has commenced using the interRAI tool with one RN having completed the course. No files reviewed evidenced the use of interRAI assessment tool by the service.  Seven relatives (five rest home and two hospital) and seven residents interviewed (three rest home and four hospital) interviewed are very satisfied with the support and care provided. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Residents’ personal needs information is gathered during admission by the registered nurse. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans include input from a general practitioner, support services and medical specialists as appropriate |
| **Finding:** |
| (i)One rest home resident does not have a pain assessment; (ii) Two residents (one hospital and one rest home) do not have continence assessment; (iii) three residents (one hospital and two rest home) do not have nutrition assessment; (iv) one rest home resident does not have a challenging behaviour assessment. |
| **Corrective Action:** |
| (i) Ensure that all residents have a pain assessment on admission; (ii) Ensure that all residents have a continence assessment as required; (iii) Ensure that all residents have a nutritional assessment on admission; (iv) Ensure that all residents with identified challenging behaviour have a behavioural assessment completed. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Previous certification audit identified that long term care plans and wardrobe care plans did not align and that not all care requirements were documented on care plans. Six resident files were reviewed (two rest home and four hospital). Five of six care plans (two rest home and three hospital) identified that the initial care plan was completed within 24 hours of admission. The service has ceased using an auxiliary care plan which was stored in the resident’s wardrobe. This previous care plan recorded the resident’s daily hygiene requirements, mobility and transfers, continence and nutrition and hydration needs. A nursing care plan in the resident file recorded specific nursing interventions for clinical needs. The service is no longer using the ‘wardrobe’ care plan, however the file long term care plan has not been altered to ensure that all resident needs are documented within this plan. In all six files sampled there is lack of documented interventions in the long term care plan to support and address all resident’s needs. Improvements continue to be required in this area. One palliative resident did not have an initial care plan developed. Improvements are required in this area. All six files sampled identified that the long term care plan was completed within three weeks. There is evidence of six monthly reviews which are signed by a registered nurse. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Initial care plans were developed for five of six resident files reviewed. The initial care plan is based on initial assessments and information received from resident, family and transfer information. The initial care plan includes sections for: mental state, hearing, sight, mobility, pressure area care, shower/bath, hair washing, dressing, oral hygiene, toileting, diet, medication, rest and sleep, risk factors, social contacts, recreation and special instructions/personal preferences. A long term care plan is developed which addresses specific nursing and clinical issues and goals e.g. diabetes management, falls management, pain management. The long term care plan does not include all other activities of daily living requirements. |
| **Finding:** |
| a) One hospital level palliative care resident did not have an initial care plan developed; b) long term care plans do not include all aspects of resident care requirements including activities of daily living. |
| **Corrective Action:** |
| a) Ensure all residents have an initial care plan developed to record the level of care and support required; b) ensure that the long term care plan includes and addresses all care requirements. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist. Activity assessments and the activities sections in care plans have been completed by the activities coordinators. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, health care assistants, and registered nurses. There is evidence of three monthly medical reviews in three (one rest home and two hospital) of six files. Three of the residents have not been at the service for three months. The manager and clinical managers are responsible for the education programme and ensure staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Progress notes are written on every shift by health care assistants and registered nurses (evidenced in all six residents' progress notes sighted). When a resident's condition alters, the registered nurses advise that they initiate a review and if required, arranges a GP visit or a specialist referral. However on review of six files, two hospital files did not evidence that a review and amendments had been conducted when the residents care needs changed. There are short term care plans (STCP) to focus on acute and short-term issues. STCP’s reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. However, short term care plans are not in use for all identified short term issues including skin tears, medication errors and injuries. This remains an improvement from the previous audit.   The six health care assistants, four registered nurses, one enrolled nurse, two clinical managers and the nurse manager interviewed stated that they have the equipment necessary to provide care, including transfer belts, wheelchairs, wheel chair platform, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Seven residents interviewed (three rest home and four hospital) and seven relatives (five rest home and two hospital) interviewed were complimentary of care received at the facility.  D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for 28 residents with wounds which includes; five pressure areas, 12 skin tears, four skin break downs, two ulcers, two blisters, one skin cancer and two skin infections. Improvements are required in relation to wound documentation and evaluation. The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services have been provided in April 2013 and March 2014 and wound management in-service have been provided in May 2013.   During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents’ rooms and ensured residents’ dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.  The sample of files reviewed included; Hospital: One resident under 65 years, one resident for palliative care, one resident with a pressure area and one resident with a recent hospital admission. Rest home: One resident with cultural needs and one resident with challenging behaviours. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| All six files identified that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses. The care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist. The six health care assistants, four registered nurses, one enrolled nurse, two clinical managers and the nurse manager interviewed stated that they have the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Residents and relatives interviewed were complimentary of care received at the facility. Wound assessment and wound management plans are in place for 28 residents with wounds. There are short term care plans to focus on acute and short-term issues for some resident issues. STCP’s reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. However, short term care plans are not in use for all identified short term issues including skin tears, medication errors and injuries. |
| **Finding:** |
| (i) In two of the files sampled (hospital), interventions were not documented in care plans to address all current needs – in one hospital file sampled there was no documented evidence of a management plan for identified challenging behaviours; one resident had documented evidence of three falls in March 2014 with no evidence of interventions or goals for falls prevention. (ii) 17 of the 28 wound care plans did not show evidence of frequency of wound dressing or evaluation, two wounds did not show evidence of frequency of dressing, one wound had no documentation since 29 April 2014 and one wound had no treatment record since 9 April 2014, however there was a written evaluation on 29 Aril 2014; (iii) On review of a sample of incident reports (#1.2.4), it was noted that there were no short term care plans developed for three residents with documented skin tears, one resident with a documented medication error, one resident with a documented reddened area on the back/shoulder and one resident with a documented head injury including no documented evidence of neurological observations completed |
| **Corrective Action:** |
| (i) Ensure that care plans include all required interventions to address current health changes. (ii) Ensure that all wound care treatment has documented evidence of frequency of dressings, evaluations of the wound and appropriate/timely documentation; (iii) Ensure that all residents with acute issues have a short term care plan developed by the registered nurse or amendments are made to the long term care plan. |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two activities coordinators at Wesley Rest Home and Hospital, both of whom are responsible for the planning and delivery of the activities programme in the rest home and the in the hospital. Both activities coordinators have been employed for over 2 years and one is a diversional therapist. One of the coordinators works thirty hours per week and the other forty hours per week Monday-Friday. There is also another staff member employed for forty hours as the residents advocate and helping with activities. There are two separate weekly programmes (one for rest home and one for hospital) and residents can attend either programme depending on their abilities. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident’s rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and a copy of the programme is given to all residents and a copy on the notice boards. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history/residents profile is conducted. A care plan for activities is developed with goals and interventions. This is reviewed six monthly with two monthly progress notes written. A record is kept of individual residents activities. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There are a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. The activities coordinators meet with the manager and clinical manager monthly to review the programme. The residents have a meeting four times a year and feed- back regarding activities is welcomed. An activities survey was carried out last year. WesleyCare rest home and hospital has its own van for transportation. Residents interviewed described attending concerts, going out for lunches and picnics, and shopping. The activities coordinators have a current first aid certificate. 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is at least a three monthly review conducted by the medical practitioner.  D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly as sighted in three care plans sampled (two from the hospital and one from the rest home). The other three residents files sampled have not yet been at the service for six months. Evaluations are conducted in relation to each nursing goal recorded on the long term care plan (link #1.3.5.2, 1.3.6.1). There are short term care plans (STCP) to focus on acute and short-term issues. STCP’s reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. However, short term care plans are not in use for all identified short term issues including skin tears, medication errors and injuries. This was a previous audit finding (link 1.3.6.1) and remains an area requiring improvement. Health care assistants interviewed confirmed that they are updated as to any changes to/or in resident’s care or treatment during handover sessions which occur at the beginning of each shift. Communication books are in use and staff advised that they read care plans and progress notes prior to commencing their shift. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **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. Residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication by the GP. WesleyCare rest home and hospital uses the four weekly blister pack system. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy The medication trolleys are kept in the locked treatment rooms in the hospital third floor, rest home and hospital unit (Marblewood studio units, and houses). 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. Education on medication management occurred in July 2013 with competencies conducted for senior health care assistants with medication administration responsibilities. Registered nurses also completed medication competencies however, three registered nurses staff files reviewed evidence that medication competency has not been maintained annually. This is an area requiring improvement. Signing sheets are in place for packed medication, short term, and prn medication. The service has adequate information and supervises the self-administration of medicines. There were no residents self –administrating medications. Advised by the registered nurses that self-administered medications would be securely stored in locked drawers in the resident’s room.   The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents’ medication charts and resident files on the front page.  Twelve medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. PRN mediation charted by the GP had indication for use. Staff signed appropriately for prn medication including time given. Effectiveness of prn medication is recorded in the progress notes. This was a previous audit finding that is now being monitored and addressed.  Medications were safely stored on the trolleys which are kept in a locked treatment rooms when not in use. All medications were up to date. All medications were safely stored. This was a previous audit finding that is now being addressed and monitored. Five of eleven rest home residents individual eye drops were not dated on opening. This is an area requiring improvement. There were residents currently prescribed regular controlled drugs. The controlled drugs were not locked away in the controlled drug safe. There are two controlled drug safes, one on the hospital third floor which is used by the hospital and rest home, and one in the Marblewood hospital treatment room used for hospital resident in Marblewood hospital unit. The controlled drug registers show evidence of weekly checks and weekly quantity stock accounts. The registers show evidence of two staff when signing out controlled drugs. Three RNs and one EN were observed safely administrating medications at the breakfast and lunch time medication rounds. There are two medication fridges one on the hospital third floor treatment room and one in the Marblewood hospital treatment room. There was no documented record of the two medication fridge temperatures. This is an area requiring improvement. |

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

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

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| **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. Residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication by the GP. WesleyCare rest home and hospital uses the four weekly blister pack system. Verification is completed by the RN against the drug chart on arrival from the pharmacy. There is a signed agreement with the pharmacy |
| **Finding:** |
| (i) Five of eleven rest home residents individual eye drops were not dated on opening. (ii) Temperatures of medication fridges in the treatment room in the hospital third floor and in the treatment room in Marblewood hospital were not evidenced as being monitored or recorded. |
| **Corrective Action:** |
| (i) Ensure that all eye drops are dated on opening. (ii) Ensure that temperatures of the medication fridges in the hospital third floor treatment room and Marblewood treatment room are monitored and recorded daily. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Senior health care assistants, enrolled nurses and registered nurses are responsible for medication administration. Education relating to medication management was provided in July 2013 and in relation to controlled drugs in March 2014. Registered nurses complete syringe driver training and associated competencies (April 2014). Medication administration competencies are conducted for senior health care assistants, enrolled nurses and registered nurses on an annual basis. |
| **Finding:** |
| Three registered nurse staff files reviewed evidenced that medication competency has not been maintained annually. |
| **Corrective Action:** |
| Ensure that all registered nurses have medication competency conducted annually. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| WesleyCare rest home and hospital has a commercial kitchen where all food for the rest home and third floor hospital is cooked on site. There is also another kitchen in the adjoining hospital unit that prepares food for the hospital residents in the studio units and the house wings. The cook in the rest home has been employed for thirty years and works 7.30am-4pm four days per week with another cook for the remaining three days. There is a kitchen assistant and tea cook who works until 6pm. The cook in Marblewood has been employed for twenty five years and works 6.30am-3pm four days per week with another cook working the three remaining days. There is a kitchen hand who works 6.30am-1pm. All kitchen staff have completed food safety training. There is a five weekly rotating winter and summer menu. The menu has been approved by a dietitian. 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. Food is served hot directly from the Baines Marie in the rest home. In the hospital unit the food is delivered to the wings in hot boxes having been served directly from the kitchen. All fridges and freezers temperatures are recorded daily on the recording sheet sighted in the rest home kitchen. Temperatures of fridges and freezers in Marblewood hospital unit kitchen were not evidenced as recorded. This is an area requiring improvement. Food temperatures are monitored and recorded weekly. This is an area requiring improvement. All food in the fridge and pantry is covered, labelled and dated. All food is stored off the floor in the pantry. 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 cooks interviewed. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include pureed diets, soft diets, and cultural needs. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served and were attractively presented. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There are snacks available for residents including home baking. 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| WesleyCare rest home and hospital has a commercial kitchen where all food for the rest home and third floor hospital is cooked on site. There is also another kitchen in Marblewood hospital unit where food for the hospital residents in the studio units and the house wings is prepared. All kitchen staff have completed food safety training.  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. All fridges and freezers temperatures are recorded daily on the recording sheet sighted in the rest home kitchen.  Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served and were attractively presented. 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. |
| **Finding:** |
| (i) Temperatures of fridges and freezers in Marblewood kitchen were not evidenced as recorded. (ii) hot food temperatures in both kitchens and kitchenettes are insufficiently monitored and recorded |
| **Corrective Action:** |
| (i) Ensure that temperatures of fridges and freezers in Marblewood hospital unit are monitored and recorded. (ii) Ensure that hot food is monitored and recorded in line with safe food practices. |
| **Timeframe (days):** 60 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| WesleyCare rest home and hospital provides services across two adjacent buildings. Both have a current building warrant of fitness certificate which expire on 1 January 2015. Hot water temperatures are monitored in both buildings and while the recorded temperatures are above the expected levels, the service advises that every effort has been made to rectify the problem. When a water temperature is identified as being higher than 45 degrees, the service places signage at the tap to alert residents and staff that water is hotter than it should be. There have been no issues of burns or scalds reported. The DHB are aware of the issue and have monitored the finding through previous corrective actions. The new building scheduled for completion in October 2014 will eliminate this issue with a new water heating system in place. The service has addressed this previous finding. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Fire evacuation drill was conducted on 12 December 2013. Fire safety is part of all new staff orientation and induction. First aid training has been provided for all registered nurses – completed in September 2013. Three RN staff files reviewed evidenced current first aid certificates. The service has addressed and monitored this previous finding. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has five rest home residents with restraint, one with an enabler; 10 hospital residents assessed as requiring enablers and 13 hospital residents with restraint. Restraint includes the use of bedrails and lapbelts. There is a restraint register and an enabler’s register. The 11 enablers include five with bedrails, four with bedrails and a lap belt and two with a lap belt. Restraint (18) includes seven residents with bedrails, and 11 with bedrails and a lap belt. Staff receive training in restraint minimisation and challenging behaviour management. Competencies are also completed. The service has addressed and monitored the previous findings relating to monitoring of restraint and conducted three monthly restraint reviews. Policy dictates that enablers should be voluntary and the least restrictive option possible. The staff interviewed are familiar with this. Restraint/enabler use is discussed at quality assurance meetings, and three monthly restraint meetings. Restraint use audit was conducted in 2013. Staff received training around restraint minimisation and safe practice in January and March 2014. Management of challenging behaviours education was provided in April 2013. Restraint questionnaires and competency are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified that monitoring of restraint was not always conducted and recorded. On review of one resident with an enabler and three residents with restraint evidenced that monitoring forms are in place and completed when the device is in place. Monitoring is conducted at least two hourly and this is recorded in the resident’s care plan. The service has addressed and monitored this previous finding. |

##### **Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

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

#### Standard 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified that review of restraint use had not been conducted three monthly as per restraint policy. On review of four resident files – one enabler and three restraint, there is evidence of three monthly restraint reviews for individual residents and a restraint committee meets three monthly to review restraint use in the facility. The service has made improvements in this area. |

##### **Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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 3.3: Policies and procedures **(**HDS(IPC)S.2008:3.3)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous audit identified infection prevention and control policies were not current and did not include all information required to guide staff. The service has purchased Bug control manuals for 2014 which include all required policies – hand hygiene, surveillance, management of outbreaks, anti-microbial use, standard and additional precautions as well as reviewing WesleyCare infection control manuals and documentation (May 2013). Education for staff was last provided in February 2013 and is planned for 2014. A registered nurse is the facility infection control coordinator. The service has addressed and monitored this previous finding. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. The service has addressed and monitored this previous finding. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality assurance meetings, and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. A registered nurse is the designated infection control nurse and has attended infection control training in 2013. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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