

# Strathallan Healthcare Limited

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Current Status: 5 June 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

Strathallan Lifecare is certified to provide rest home, hospital and dementia level care for up to 76 residents. On the day of audit there are 20 dementia, 29 rest home and 26 hospital residents. The general manager has experience in aged care and health management roles and has been in the position for approximately ten years. She is supported by an assistant manager and three care managers, all are experienced registered nurses. Staff interviewed and documentation reviewed identifies the service has systems being implemented that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke positively about the care and support provided.

This audit also verified the reconfiguration of eight rest home rooms and one studio unit as suitable for hospital or rest home level care.

The three shortfalls identified in the previous audit have been addressed. This surveillance audit identified no additional shortfalls.

## Audit Summary as at 5 June 2014

Standards have been assessed and summarised below:

### Key

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

#### Consumer Rights as at 5 June 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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#### Organisational Management as at 5 June 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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#### Continuum of Service Delivery as at 5 June 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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#### Safe and Appropriate Environment as at 5 June 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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#### Restraint Minimisation and Safe Practice as at 5 June 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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#### Infection Prevention and Control as at 5 June 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Strathallan Healthcare Limited
<b>Certificate name:</b>	Strathallan Healthcare Limited

<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
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<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Strathallan Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 5 June 2014 <b>End date:</b> 6 June 2014

<b>Proposed changes to current services (if any):</b> The service proposes to reconfigure eight rest home rooms to utilise as dual-purpose beds for rest home/hospital level care and one studio unit as for rest home or hospital level care.
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<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	29
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## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed	7	Number of staff interviewed	12	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	8	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	105	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Tuesday, 1 July 2014

## Executive Summary of Audit

### General Overview

Strathallan Lifecare is certified to provide rest home, hospital and dementia level care for up to 76 residents. On the day of audit there are 20 dementia, 29 rest home and 26 hospital residents. The general manager has significant experience in aged care and health management roles and has been in the position for approximately ten years. She is supported by an assistant manager and three care managers, all are experienced registered nurses. Staff interviewed and documentation reviewed identifies the service has systems that are being implemented that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke positively about the care and support provided.

The three shortfalls identified in the previous audit have been addressed. This surveillance audit identified no additional shortfalls.

### Outcome 1.1: Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. There is a complaints register that is maintained. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints. There has been one complaint in 2014 relating to lost resident property, all files sampled have a valid advance directive.

### Outcome 1.2: Organisational Management

Strathallan has a quality and risk management system that is implemented and monitored. This is linked to a business plan and goals. The service is active in implementing service improvements. The service is active in analysing data and Strathallan is part of the Hurst Holdings benchmarking programme across the four facilities. There is an internal audit programme in place and where corrective actions are identified these are seen to be monitored and resolved. The incident reporting system is utilised and data used to improve service delivery. Resident meetings are held monthly. Annual resident and relative survey completed February 2014 resulted with an overall impression described as very good. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an implemented planned annual in-service programme for all staff that includes on-going training. Staff training records are maintained, annual performance appraisals are completed. Staff relatives and residents reported that staffing levels are sufficient.

### Outcome 1.3: Continuum of Service Delivery

Lifestyle plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed three to six monthly following admission. Residents and/or family have input into the development of lifestyle plans. Communication with family is well documented. All residents have an individualised lifestyle plan that reflects current needs. These are reviewed three to six monthly and updated as needs change.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity lifestyle plans included in the long term lifestyle plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly.

An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Registered nurses administer medications in hospital and registered nurses, enrolled nurses or senior caregivers administer medications in the rest home and the dementia unit. Staff responsible for medicine management have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. Residents that self-administer have three monthly competency assessments. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site. All kitchen assistants employed by the service have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

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

Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 1 May 2015. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule. Medical equipment has been calibrated. Hoists were serviced on 22 October 2013. The service proposes to reconfigure eight rest home rooms to utilise as swing beds for rest home/hospital level care and one studio unit as swing bed for rest home/hospital level care. This audit identified that following a visual inspection of these rooms are suitable for hospital level care delivery.

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

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has restraint (chair restraint and bedrails) being utilized for four residents and enablers (bedrails and foot rest) being utilized for five residents. Restraint usage has decreased in 2013/2014 with introduction of alternative strategies. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint meetings. Restraint and enabler monitoring occurs. Restraint minimisation and challenging behaviours and de-escalation in service has been provided to staff. The service has introduced a philosophy of Dementia without drugs and Spark of Life.

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

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The service has effective surveillance activities, subsequent actions and implementation of strategies for prevention and minimisation of infection and these are well documented. Benchmarking occurs within the Hurst Holdings group providing opportunities for continuous improvement. Education is provided and evaluated for through surveillance to determine infection control activities, resources and education needs within the facility. There are audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	42	0	0	0	0	0

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

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D 12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

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

D16.4b Seven relatives (two from the rest home, three from the hospital and two from dementia), stated that they are always informed when their family members health status changes. Incident forms for April 2014 indicate that family are informed.

Resident meetings are held monthly. Annual resident and relative survey completed March 2014 resulted with an overall impression described as very good.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

**Standard 1.1.13: 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

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

D13.3 h: A complaints procedure is provided to residents and their family within the information pack at entry. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau. Seven of seven residents (four from the rest home and three from the hospital) and seven relatives (two from the rest home, three from the hospital and two from dementia) interviewed confirm they are aware of the complaints process and they would make a complaint to the manager if necessary. There is a complaints register in place. A complaints folder is maintained with the documentation related to each complaint including sign off of the complaint.
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**Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

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

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Strathallan Lifecare is certified to provide rest home, hospital and dementia level care for up to 76 residents. On the day of audit there are 20 dementia, 29 rest home and 26 hospital residents. The general manager has significant experience in aged care and health management roles and has been in the position for approximately ten years. She is supported by an assistant manager and three care managers, all are experienced registered nurses. Strathallan has a documented philosophy for the facility. There is a generic Business Plan for the Hurst Group that identifies goals for 2013/2014. The goals are agreed at the forum attended by the General Managers of the facilities within the group. Goals include: maintain reputation and occupancy, operating within budget, environment maintenance, staff training and implementation of innovative services. Progresses toward these strategic goals are discussed at general manager (and board) level.

D17.3di (rest home), D17.4b (hospital): The general manager has maintained professional development activities related to managing a rest home/hospital.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The service has introduced a philosophy of Dementia without drugs and Spark of Life programme.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a business plan that includes quality goals. Quality Plan goals for 2013/2014 include; i) swing bed reconfiguration, ii) benchmarking, iii) introduction of interRAI, iv) reduction of staff turnover in dementia, v) building of apartments, vi) redevelopment of dementia outside environment, and vii) reducing incidence of skin tears. Annual review has occurred in January 2014 for the 2013 infection control programme, risk management, complaints and concerns, and restraint/enabler use.

Policies and procedures are reviewed at least two yearly. There is an internal audit schedule.

Quality improvements are established when issues are identified. Quality initiatives include: reducing incidence of skin tears with a review of risk factors, reason for occurrence, preventative measures including skin integrity; reducing interruptions for staff administering medication, thus reducing medication errors; introduction of breakfast club in dementia unit; and a health and well-being challenge for staff including exercise and healthy diet. Quality data is collected and evaluated and a benchmarking programme across the group has recently commenced. Key components of the quality system link to service delivery. There are linkages to quality, registered nurse and staff meetings, keeping all staff informed of quality improvements occurring.

There is an up to date risk management and hazard management plan and health and safety policies that include hazard identification.

Resident/relative survey occurred in March 2014 with overall satisfaction to delivery of care and services.

D5.4 Strathallan has the following policies/ procedures to support service delivery;

- 1) Contenance Policy. Contenance assessments were evident in resident files.
- 2) Challenging behaviour policy. A challenging behaviour assessment and management plan is used for residents with challenging behaviours.
- 3) Pain management policy and procedure. There is an assessment tool and monitoring of the effectiveness of pain medication documented.
- 4) Personal grooming and hygiene policy.
- 5) Pressure are risk management policy. One resident from the hospital has a grade I sacrum pressure area. There was documented evidence of the service involving DHB wound care specialist in the care of wounds.
- 6) Wound assessment and wound management plans are in place for fifteen residents with wounds (link # 1.3.6)
- 7) Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

D10.1 A policy around death and dying. The policy outlines immediate action to be taken upon a resident's death and that all necessary certifications and documentation is completed in a timely manner.

Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, post falls review of falls assessment risk and the identification of interventions on a case by case basis to minimise future.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p>
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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 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the

status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an accident and incident policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise risk and debriefing. Incidents, accidents and near misses are documented. Incidents are analysed on a monthly basis and trends identified. Benchmarking occurs with other facilities in the Hurst Group. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

Incident forms reviewed for April 2014 identified incident forms were reviewed across the service and all demonstrated clinical follow up by the clinical manager and monitoring (such as neurological observations) having been undertaken when indicated. All incident forms identified family notification (or reason why not notified). The six resident files reviewed (two from the hospital, two from the rest home and two from dementia), indicate that incidents are noted in the progress notes for January to April 2014 and have a corresponding incident form.

Discussions with the general manager and registered nurses confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (clinical manager, registered nurse, three caregivers, cook, activity co-ordinator and kitchen assistant/cleaner). All eight files had up to date performance appraisals. The service maintains annual practicing certificates for all health professionals.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice.

There is an annual education schedule for 2014, including competencies specific for registered staff, that exceeds eight hours annually. All staff have current first aid certificates. Individual in-service records are maintained.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies. Of the 15 care staff who work in the dementia unit 11 have completed dementia specific standards, four are currently working towards achievement.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The service contracts with allied health professionals on an as required basis.

General Manager (RN): fulltime

Assistant Manager (RN): fulltime

Care manager: (hospital) fulltime

Care manager: Across (rest home) and (dementia) fulltime

(Dementia) - 20 residents

AM: 1x registered nurse (RN)/ enrolled nurse 0730-1600, 1x caregiver 0700-1500, 1x caregiver 0700-1230

PM: 1x RN/senior caregiver 1600-midnight, 1x caregiver 1500-2130, 1x caregiver 1635-21500

Activities: - 1x 0930-1700 Monday to Friday; 1x 1600-2000 Monday to Friday; 1x 1715-1930 Sat/Sun; 1x 1515-1645 Sat/Sun

(Rest home) - 28 residents

AM: 1x RN 0900-1700, 1x EN 0730-1615, 1x caregiver 0730-1315, 1x caregiver 0630-1215, 1x caregiver 0700-1530

PM: 1x RN/enrolled nurse 1600-2200, 1x senior caregiver 1600-2200, 1x caregiver 1645-2015, 1x caregiver 1530-midnight

Activities: 1x 0930-1230 and 1x 1300-1700 Mon-Wed, 1x 1000-1700 Thurs. /Fir, 1x 1315-1515 Sat/Sun

(hospital) 25 residents

AM: 1x RN 0645-1500, 1x EN 0800-1330, 2x caregiver 0700-1500, 1x caregiver 0730-1330, 1xcaregiver 0730-1230, 1x caregiver 0730-1300, 1x caregiver 0800-1230, 1x senior caregiver 0800-1330 Sat/Sun

PM: 1x RN 1445-2300, 1xcaregiver 1500-2300, 1x caregiver 1500-2200, 1x caregiver 1600-2100, 1x senior caregiver 1630-2100, and 1 x senior caregiver 1530-1800 Sat/Sun

Activities: 1x 1330-1530

Night Duty (across facility)

1x RN 2245-0700, 2x caregiver 2300-0700, 2x caregiver midnight-0730

Cleaning staff -1x 0745-1045, 1x 0900-1300, 1x 0900-1200, 1x 0730-1130, and 1x 0900-1130.

Laundry staff -1x 0900-1430, 1x 1900-2300, 1x 1215-1515.

Kitchen- Cook 1x 0615-1015, 1x 0900- 1800. Kitchen Assistant-1x 0730-1330, 1x 1500-1945, 1x 0800-1345, 1x 1530-2015.

Staffing is flexible to provide sufficient coverage for the delivery of hospital level care in rest home dual-purpose beds and studio unit reconfiguration.

There is a staff numbers, hours and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers.

There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Interviews with one registered nurse, one care supervisor, two caregivers, seven residents and two 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Clinical records include the time of entry of the record, a legible signature or the printed name alongside the non-legible signature, and the designation of the healthcare provider making the entry. Shortfall from previous audit is now met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy and process that describe resident's admission and assessment procedures.

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.

Activity assessments and the activities sections lifestyle plans have been completed by the diversional therapist in the rest home and hospital and the diversional therapist in the dementia unit.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) nutritional assessment and g) pain assessment.

Lifestyle plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. There are clear resident focused goals at the start of the lifestyle plan. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. This was observed in the hospital.

All six files (two from the hospital, two from the rest home and two from dementia) identified integration of allied health including district nurses, nurse practitioners, mental health services, oncology, DHB nurse specialist, physiotherapy, geriatrician, NASC, and podiatry. The GP interviewed spoke very positively about the service and describes effective communication processes.

D16.2, 3, 4: The six resident files reviewed (two from the hospital, two from the rest home and two from dementia), identified that in all six files a nursing assessment was completed within 24 hours and six of six files identify that the long term lifestyle plan was completed within three weeks. There is documented evidence that the lifestyle plan were reviewed by a RN and amended when current health changes. Four of six lifestyle plans reviewed evidenced evaluations completed at least six monthly. Two residents had been in the facility less than six months.

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.*

Tracer Methodology Dementia

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service provides services for residents requiring rest home level care, hospital level care and dementia care. Lifestyle plans are completed comprehensively. Six resident files (two from the hospital, two from the rest home and two from dementia) were reviewed for this audit.

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident. Lifestyle plans evidenced at least three monthly for hospital residents and six monthly for rest home and dementia lifestyle plan reviews. The use of short term care plans are evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with four caregivers who work both am and pm shifts and who work across rest home, hospital and dementia levels of care, seven family members (two from the rest home, three from the hospital and two from dementia), one RN, one care manager, one clinical coordinator, one assistant manager and one general manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. The GP has been attending the service since opening.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses, hospice, psychogeriatric nurses, gerontology nurse specialist, nurse practitioner, geriatrician, and NASC. There is also evidence of community contact.

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

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services (May 2014 31 staff attended) and wound management (May 2014 RNs attended) in-service have been provided.

Wound assessment and wound management plans are in place for fifteen residents with wounds. One resident from the hospital with lesions also has XXXXX. Skin tears and minor wounds are initially documented on a form for skin tears/minor wounds and either resolved or transferred to a wound care plan by the registered nurse. On interview the RN, care manager and clinical coordinator stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are three activities coordinators, two diversional therapists (DT) and one occupational therapist (OT) employed by the service. One DT has been employed for 10 years and works in the dementia unit. The other DT has been employed for two years and works in the rest home and hospital. The OT has recently been employed to work in the dementia unit. The three other activities coordinators work between the rest home, hospital and dementia unit. Activities are covered from 9.30am-5pm and in the dementia unit until 8pm. The service has introduced a breakfast club in the dementia unit and activity staff start at 7.30 am to manage this. Breakfast is set up in the dining room and residents attend the dining room if they wish in their night wear and are supervised to help themselves. The assistant manager described this being more person focused, promoting independence, maximising functioning and keeping the residents active in normal daily activity. The service has also produced a book about the breakfast club for residents, staff, relatives and visitors to read. The service also has several volunteers that assist with activities. The activities staff and management meet monthly to plan the activities as a team. Copies of the programme are given to each rest home and hospital residents. Copies are available on the notice boards and the lounges.

All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and dementia lounge. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family. And a lifestyle plan is developed with residents goals. The activities staff are involved with resident's evaluation three – six monthly and write weekly activity progress notes. Daily attendance records are kept. The activities staff have attended training sessions with the Dunedin diversional therapy group and interact with other activities coordinators in the area.

Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing alongs, bingo, movies, RSA visits, visits to other facilities and outings including shows in Timaru. There is a community knitting circle that the community attends and the service picks up people from the community to attend activities at the service. The service has two vans one of which is a wheelchair van. Outings are daily for the dementia unit, twice a week for rest home residents and monthly for hospital residents. The activity staff drive the van. The service has an indoor swimming pool, pool room and gym. All residents at the service have access to these recreational amenities and volunteers help. All seven residents (four from the rest home and three from the hospital) and seven relatives (three from the hospital, two from the rest home and two from dementia), interviewed stated they were happy with the activities available and are given a choice regarding attendance.

The service is currently making changes to the dementia outdoor area following research and a consultation process with staff and relatives. The new secure area will include safe sensor loop walking areas with garden planting, a water feature intended to be used as a quiet area, sculptures, scenery panels on fences, bird aviary, gazebo, blokes shed, garden shed and vegetable and garden planning area.

All activity staff have completed first aid training.

The activity programme is adequate to accommodate adequate an extra six beds to be used for either rest home or hospital level residents as required.

D16.5d: four resident files reviewed identified that the individual activity plan is reviewed when at lifestyle plan review two resident files viewed had been in the facility less than six months.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All initial lifestyle plans were developed by an RN within three weeks of admission and evaluated at least three monthly for hospital residents and six monthly for rest home and dementia residents or if there is a change in health status. There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in four of six lifestyle plans reviewed, two residents had not been at the facility for longer than six months. Overall changes in health status are documented and followed up. Lifestyle plan reviews are signed as completed by an RN. GP's review residents medication at least three monthly or when requested if issues arise or health status changes.

There are short term lifestyle plans (STCP) to focus on acute and short-term issues. STCPs reviewed evidenced evaluation and are signed and dated by the registered nurses when issues have been resolved. Staff are informed of any changes to residents need at hospital handover, evidenced during the audit. Examples of STCP's included: weight loss, infections and wounds. Minor wounds including skin tears are documented and reviewed on a skin tear/minor wounds form. These are used for wounds that are expected to heal quickly. Wounds that take longer to heal and transferred to a wound assessment and treatment form for management.

Caregivers interviewed confirmed that they are updated as to any changes to/or in residents care or treatment during handover sessions at the beginning of each shift.

D16.4a Lifestyle plans are evaluated six monthly or more frequently when clinically indicated.

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident.

Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member.

Resident medication charts are identified with demographic details and photographs. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 12 medication charts had allergies (or nil known), documented. All PRNs have documented indication for use by the GP and a record is kept of PRNs given with reason for use and evaluation. All eye drops (six in the hospital, seven in the rest home and three in the dementia unit) in use have a date of opening sighted. The service documents adverse reactions and errors on incident/accident forms.

There are two locked cupboards that are used for controlled drugs one for the hospital and one for rest home and dementia unit. Two signatures were evident for all controlled drugs. Weekly and six monthly checks were evident. There are drug trolleys that are kept in the nurses' stations which are locked when not in use.

Medication round observed in three areas; all practice is appropriate.

A medication competency has been completed annually by all staff who administer medication including, blood glucose monitoring, insulin administration, oxygen and nebuliser, syringe driver and drug administration. Medication in service management was completed in July 2013 and 29 staff attended.

There is a policy and process that describes self-administered medicines. There is currently one resident who self-administer medication inhalers only. The resident has a current competency assessment which is reviewed three monthly.

D16.5.e.i.2: 12 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service employs one chef and six cooks. Four cooks are employed at the service part time. The chef has been employed for two years and works full time 8am -6pm. The main cook has been employed for 10 years and works 9am-6pm. The service also employs seven kitchen hands that work during the day and in the evening. All staff that work in the kitchen have completed food safety training. The service has a commercial kitchen and all food is prepared on site. The kitchen and the equipment are well maintained. The kitchen is adequate to accommodate an extra eight beds to be used for either rest home or hospital level residents and one studio unit as required. There is a rotating five weekly winter and summer menu in place that has been approved by a dietitian. The menu was last approved in April 2014. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. An RN completes each resident's nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen including mouli, puree, soft, gluten free and those residents with food allergies. The cook described special diets and in particular fortified diets to residents that have been losing weight. Extra puddings, protein drinks and food supplements are used.

Food safety information and a kitchen manual are available in the kitchen. Food is served to the rest home and dementia residents direct from the baine maire in the kitchen through two separate kitchen serveries. The food for the hospital residents is transported to the hospital servery in hot boxes and then transferred to the baine marie and served from the bane marie. Food served on the day of audit was hot and well presented.

The service encourages residents to express their likes and dislikes and this is documented on the dietary profile form and a copy is kept in the kitchen folder. The likes and dislikes of the residents are also noted on the kitchen whiteboard that is seen only by staff. The residents interviewed spoke highly about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch

Fridge/freezer temperatures are checked daily (sighted). The chef/cook checks food temps prior to serving and the kitchen assistants check the food temps prior to serving the hot meal in the hospital (sighted). Temperatures of tea meals are also checked and documented. Food in the fridge and chiller were covered and dated. Decanted foods were dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away. There is a weekly schedule of kitchen cleaning tasks.

Food audits are carried out as per the yearly audit schedule. Feedback regarding food services from February 2014 surveys reports overall satisfaction.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 1 May 2015. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule. Medical equipment has been calibrated. Hoists were serviced on 22 October 2013.

The service proposes to reconfigure eight rest home rooms to utilise as dual-purpose beds for rest home/hospital level care and one studio unit as dual-purpose for hospital level care. This audit identified that following a visual inspection of these rooms are suitable for hospital level care delivery. Rooms are large enough to manoeuvre a hoist should it be required. They have their own en-suite and there is adequate room in lounges and dining rooms to manage extra hospital level care residents. The service has appropriate equipment available e.g. hoists, pressure mattresses, low beds and lazy boy chairs.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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### **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service has restraint (chair restraint and bedrails) being utilised for four residents and enablers (bedrails and foot rest )being utilised for five residents.

Restraint usage has decreased in 2013/2014 with introduction of alternative strategies. There are clear guidelines in the policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and restraint meetings. Restraint and enabler monitoring occurs. Restraint minimisation and challenging behaviours and de-escalation inservice has been provided to staff. The service has introduced a philosophy of Dementia without drugs and Spark of Life programme.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The service has effective surveillance activities, subsequent actions and implementation of strategies for prevention and minimisation of infection and these are well documented. Annual review of infection control programme occurred in January 2014. Benchmarking occurs within the Hurst Holdings group providing opportunities for continuous improvement. Education is provided and evaluated for through surveillance to determine infection control activities, resources and education needs within the facility. There are audits of the facility, hand hygiene and surveillance of infection control events and infections.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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