CHT Healthcare Trust - Lansdowne Hospital and Rest Home

Current Status: 19 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

CHT Lansdowne provides residential care for up to 95 residents at two service levels (hospital/medical and rest home). Occupancy on the day of the audit was 63 residents at hospital level care and 30 residents at rest home level care. The facility is operated by CHT who have effective governance practices. The service is managed by a manager who is a registered nurse and has been in the role for many years. A well-developed staff education programme is implemented with compulsory external education programme enrolment for new staff.

The required improvements from the certification audit around medication and wound management have been closed out. This audit has identified improvements around “as required” medication and documentation of interventions.

Audit Summary as at 19 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 19 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.

Organisational Management as at 19 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.

Continuum of Service Delivery as at 19 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.		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 19 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.

Restraint Minimisation and Safe Practice as at 19 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.

Infection Prevention and Control as at

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 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	CHT Healthcare Trust
Certificate name:	CHT Healthcare Trust - Lansdowne Hospital and Rest Home

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Lansdowne Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 19 June 2014 **End date:** 20 June 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	93

Audit Team

Lead Auditor	XXXXXX	**Hours on site**	12	**Hours off site**	8
Other Auditors	XXXXXX	**Total hours on site**	12	**Total hours off site**	8
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXX			**Hours**	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	18	Total audit hours	42

Number of residents interviewed	4	Number of staff interviewed	13	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	62	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXXXX, 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, 29 July 2014

Executive Summary of Audit

General Overview

CHT Lansdowne provides residential care for up to 95 residents at two service levels (hospital/medical and rest home). Occupancy on the day of the audit was 63 residents at hospital level care and 30 residents at rest home level care. The facility is operated by CHT who have effective governance practices. The service is managed by a manager who is a registered nurse and has been in the role for many years. A well-developed staff education programme is implemented with compulsory external education programme enrolment for new staff. The required improvements from the certification audit around medication and wound management have been closed out. This audit has identified improvements around "as required" medication and documentation of interventions.

Outcome 1.1: Consumer Rights

There is an open disclosure policy. Interviews with residents and relatives confirm family are kept informed of their family members current health status including any adverse events. A complaints process is being implemented.

Outcome 1.2: Organisational Management

The service continues to implement a quality and risk management framework that includes management of incidents, complaints, infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. There is an appropriately experienced manager who provides guidance for the service and is supported by a clinical coordinator, registered nurses and experienced care staff. The clinical coordinator provides clinical oversight with registered nurses on at all times. There is an implemented in-service training schedule. The service has sufficient staff allocated to enable the delivery of care.

Outcome 1.3: Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are evaluated six monthly. The resident and family confirm they are involved in the care planning process and are complimentary about the staff and standard of care provided. There are improvements required around the documentation of interventions to reflect the resident's current needs and risks associated with the use of restraints and enablers. The three activity co-ordinators provide a seven day activities programme for the rest home and hospital residents that is varied, interesting and involves community visitors and outings. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. The GP reviews the medication chart three monthly. There is an improvement required around indications for use of 'as required' medication. Medirest prepare meals on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for, residents interviewed responded favourably to the food that was provided.

Outcome 1.4: Safe and Appropriate Environment

Lansdowne rest home and hospital building holds a current warrant of fitness. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. There is a planned maintenance schedule, hot water temperatures are monitored. The outdoor areas are safe and easily accessible with seating and shade.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint policy and procedure has a clear definition of restraint and enablers and includes a philosophy of restraint minimisation. There is one resident requiring restraint and seven using enablers. An enrolled nurse is the restraint coo-coordinator. Staff receive education related to restraint minimisation during orientation and as part of the education programme. Documentation is in place for assessment, approval, monitoring, review and evaluation.

Outcome 3: Infection Prevention and Control

There is an established and implemented infection control programme that is linked to the quality system including monthly reporting and monitoring of surveillance data.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	2	0	0	0
Criteria	0	39	0	2	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and desired outcomes.				
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 Low	1) Twenty nine out of thirty wound assessments are not dated or signed by the assessor. 2) One rest home resident recently admitted with high falls risk does not have a falls risk assessment completed. The same resident has a pain assessment in place however the type of pain or location is not identified on the pain assessment or initial assessment. 3) One hospital resident (frequent faller) has not had a post falls assessment following two falls over two consecutive days as per policy. 4) Risks associated with use of enablers/restraints are not identified in the care plan. There is clear differentiation required on documents between an enabler and restraint in use.	1) Ensure wound assessments are dated and signed by the assessor. 2) Ensure risk assessments are completed on admission and with risk assessments changes. 3) Ensure post falls assessments are completed as per policy 4) Ensure risks associated with the use of enablers/restraints are identified on the 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 Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Four out of 12 medication charts reviewed did not have indications for use for PRN medications.	Ensure all PRN medications have an indication for use prescribed on the medication chart.	60

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Eleven of eleven incident forms reviewed between March and June 2014 identify family were notified following a resident incident. Interview with five healthcare assistants (who work across both services, one of which is the health & safety rep) and four RN's (one of which is the infection control coordinator) inform family are kept informed. Interview with one relative whose family member speaks minimal English inform there are staff working at the facility who are able to communicate in the residents natural tongue for day-to-day care needs. Interpreter services can be accessed through the DHB if necessary.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry
D16.1b.ii 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 relatives (six hospital) stated that they are informed when their family members health status changes.
D11.3 The information pack is available in large print and this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA

Evidence:

The complaints policy to guide practice. The manager leads the investigation and management of complaints (verbal and written). Complaints are recorded on the Vcare system which can provide a register. Complaints are recorded on the 'compliments, concerns and complaints form' and are visible around the facility. Complaints are discussed at the bimonthly quality meeting and reported up through the area manager. All complaints are entered into the Vcare system. The 2014 complaints were reviewed (total five) that included one in May, four in April and one February. All complaints have been reviewed with a summary of investigation and actions taken on the complaints form. Close out letters to the complainant are evident as appropriate. A Health and Disability Commissioner's Officer complaint dating back to June 2013, is seen to have been closed out (close out letter January 2014). Discussion with residents (three rest home and one hospital) and relatives (six hospital) confirm they are aware of how to make a complaint. There have been a number of compliments that

have been received across the 2014 period.
D13.3h. a complaints procedure is provided to residents within the information pack at entry

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

CHT Lansdowne provides care for up to 95 residents across two service levels (rest home and hospital) and is part of the CHT group of facilities. On the day of audit there were 30 rest home residents and 63 hospital residents. The 40 rooms in the rest home wings have been previously assessed as dual-purpose, and at the time of this audit there are nine hospital level residents in the rest home wings.

The DHB requested information regarding the clinical management of residents in these dual purpose rooms and interview with the manager informed the hospital level wings/beds are not used as dual-purpose (i.e. For rest home residents). In respect of the rest home wings/beds, there are two rosters that can be implemented based on the number of hospital level residents in the rest home wings to ensure appropriate cover for the relevant care needs of residents. For example one roster is used when the service has 65 (plus) hospital residents and one when there are 60 hospital residents. The former was in use at the time of audit. The hospital level residents that reside in the rest home wings are reportedly 'non-complex' in terms of clinical needs, i.e., there are no PEG's or Nikki's, and each resident is individually assessed prior to being placed in the rest home wing/s. Staff employed within the last 18 months work between the hospital and rest home (verified during interview with five healthcare assistants, and four RNs), and all RN's move between service levels in order to maintain competence. Medication administration competencies are completed by staff administering drugs, and there is no adverse trending data indicating inappropriate levels of support are being provided to the hospital level residents in the rest home wings. There is sufficient equipment available to support care needs (verified during interview with five healthcare assistants and four RNs).

There are no respite, young persons or residents under the medical component of the certificate in the facility at the time of audit.

The manager reports to the area manager, who reports to CHT chief executive officer (CEO). There is a 2014-15 business plan that includes specific objectives – for example 95% completion of care reviews by due date, and specific quality goals identified for the 2014 year which include (but not limited to): a focus on 'pillars of care' (linked to the Press Ganey survey feedback results) and communication with families. Progress towards objectives and goals are reported via a monthly unit review meeting attended by the manager, area manager, CEO and finance, and quality goals are reported at facility level through the bimonthly quality meetings.

There is an established and implemented quality programme that includes discussion about clinical indicators (e.g. incident trends, infection rates), at the health and safety and infection control, and quality meetings. These meetings are held bimonthly.

The service is managed by an experienced registered nurse who has been the manager at Lansdowne since 2006, and is supported by a full time clinical coordinator (RN) and has been in this position for four years. Prior to this she was an RN in the facility. There is a team of registered nurses who have experience within the aged residential care environment. ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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:

Lansdowne is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.

Quality matters are discussed at both the bimonthly quality meetings and bimonthly health & safety and infection control meetings. Both meetings comprise a core group of staff. Meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control and incidents (and trends). Monthly accident/incident reports, infections and corrective actions results of internal audit are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff.

Lansdowne combine infection control and health & safety committees which meet bimonthly. Infections (number and type) and health and safety matters – such as staff accidents - are discussed at the relevant meeting. Meeting minutes reviewed indicate issues raised are followed through and closed out. Resident meetings (approximately four monthly) demonstrate issues are addressed, noting there are approximately 26 residents attending these meetings.

Lansdowne internal audit programme is based on the requirements of the Health and Disability Services Standards. Audit is completed six monthly and corrective action are developed as required – the last audit was completed in May (2014) and resulted in eight corrective action requests forms. At the time of audit these were in various stages of completion. The closure of corrective actions were recorded.

D19.3: There is a comprehensive H&S and risk management programme in place including policies to guide practice. Staff accidents and incidents are monitored and an annual review is completed across the CHT group.
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, lo/lo beds, assessment and exercises by the physiotherapist and sensor mats. From an organisational perspective, one of the area managers is on the National Falls Programme, with information being fed back to facility managers.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)
There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)
Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)
Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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:

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the clinical coordinator for final sign off. Family are notified. 11 incident forms were reviewed and with the exception of the four that had been written between 16 and 18 June, all had been completed and signed off (the June incidents were in the process of being signed off at the time of audit). Three resident files (on hospital level in the rest home, one rest home and one hospital) were initially reviewed and one incident (skin tear) had been reported in April and an incident form could not be located. A further three files were reviewed (one rest home and two hospital) and there was no evidence of a trend, therefore this criterion is considered to have been met.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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 human resources policies to support recruitment practices. A list of practising certificates is maintained. Eight staff files were reviewed (one diversional therapist, three health care assistants who work across service levels and shifts, three registered nurses – one being the infection control coordinator, and one enrolled nurse who is the restraint coordinator) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (five healthcare assistants, four registered nurses) were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is an education plan that includes all required education as part of these standards. The plan is being implemented. There is evidence that additional training opportunities are offered to staff such as attendance at a palliative care series and outbreak coordination. Interview with five healthcare assistants confirm participation in the ACE training programme – 17 healthcare assistants are seen to have completed the national certificate. There are four ACE assessors at the facility, an update was attended in February (2014). A competency programme is in place with different requirements according to work type (e.g. healthcare assistant, registered nurse, and kitchen). Core competencies are completed and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training.

There is a staff member with a current first aid certificate on every shift.

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. Staffing is as follows: 17 healthcare assistants in the morning (for varying times), eight during the afternoon (varying times and duties) and four on night shift (2300-0700). There are three to four (based on volume and acuity) RNs on the morning shift, three on afternoon shift and one on night duty. There is one first aid qualified person on each shift. The nurse manager and clinical coordinator alternate on-call. The service employs three activity co-ordinators - hospital 20hours per week, rest home 35 hours per week and a third activity co-ordinator is currently being orientated to cover one week day and the weekends in the rest home and the hospital unit. The healthcare assistants, residents and relatives interviewed inform there are sufficient staff on duty at all times.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; 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:

D16.2, 3, 4 A registered nurse undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. InterRAI assessments are completed with a short term care plan in place for the first three weeks of admission. A care summary is also available on the residents file. V-care computer generated long term care plans are in place within three weeks of admission in the five of six resident files sampled (three hospital, two rest home). One rest home resident has not been at the service three weeks. In five of six files sampled the InterRAI initial admission assessment and initial care plans and long term care plans are completed and signed off by a registered nurse. One rest home resident recently admitted does not have a completed initial assessment (link 1.3.6.1). Four of six long term care plans have been reviewed six monthly. Two residents (one rest home and one hospital) have not been at the service long enough for a care plan review.

A stamp (dated and signed) on the InteRAI assessments identifies the resident and/or family/whanau/representative involvement in the care planning process and the primary registered nurse (RN). A lifestyle questionnaire is completed by the resident/relative prior to admission. Activity assessments are incorporated into the V-care long term care plan which is reviewed six monthly.

Care plans are used by nursing staff and healthcare assistants (HCAs) to ensure care delivery meets the residents assessed needs. There is a verbal and written handover for healthcare assistants and registered nurses at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Progress notes are completed by the RNs and HCAs each shift. All six files identified integration of allied health including general practitioner, physiotherapist, dietitian, geriatric nurse specialist services and mental health services for the older person.

Medical assessments are completed within 48 hours of admission by the general practitioner (GP) in six of six resident files sampled. Lansdowne contracts a local GP for weekly visits and as required at other times for resident concerns and admissions. The GP (interviewed) is available by mobile 24/7. The GP is

available to meet with families. After hours calls for visits to residents are appropriate and clinical assessments have been carried out prior to the call for a visit. Locum cover is provided for GP leave. The geriatricians, mental health services for the older person and nurse specialists are accessible and provide good support. The GP states there is good support provided by the secondary services.

Tracer Methodology: Rest home resident :

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

Tracer Methodology: Hospital resident:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The service provides services for residents requiring rest home and hospital level care. Individual computer generated (V-Care) care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or nurse practitioner consultation. The four healthcare assistants and three RNs interviewed state they have all the equipment referred to in care plans necessary to provide care, including hoists (checked June 2013), electric beds, ultra-low beds , lazy boy hospital chairs, sensor mats, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, mobility aids wheelchair scale (checked June 2014), gloves, aprons and masks.

Wound assessments and treatment plans including the frequency of evaluations and dressing changes are in place for 30 wounds (includes 10 skin tears and seven pressure areas). Evaluations and dressing changes are carried out at the required timeframe. This is an improvement from the previous audit.

Pressure areas include sacral (two) buttocks, foot and coccyx (two). One pressure area XXX is stage two and one XXXX is stage three. There is evidence of GP/nurse specialist involvement as required. Body maps are used to describe location and size. Photos are taken as necessary. There is an improvement required around the completion of wound assessments. The clinical co-ordinator is able to describe the referral process around accessing wound care advice/input into wound management. There are adequate pressure area resources and interventions for pressure area management are documented in the care plan. Chronic wounds are linked to the care plan

Continence products are available and resident continence management plans are completes for residents as applicable.

A range of assessment tools available for completion on admission are (but not limited to); a) min nutritional assessment and dietary profile b) waterlow pressure area risk assessment, c) continence management plan d) FRAT falls risk assessment e) pain assessment f) wound assessment and g) depression scale. There is an improvement required around the completion of assessments.

Resident weight is recorded on admission and monitored monthly. Mini nutritional assessments are completed to assess the resident's level of risk of malnutrition. Residents with weight loss are commenced on the REAP (replenish energy and protein – food fortification intervention therapy). There are three levels to the programme that ranges from additional nutritious snacks in between meals to custards made with fortified milk for supper. Resident's food and fluid intake is monitored and the resident is weighed more frequently. The GP and dietitian are made aware and next of kin are notified as evidenced in documentation. Speech language therapists are accessed for residents with swallowing difficulties.

Consents and assessments are completed for the use of restraints and enablers. Healthcare assistants sign the monitoring checklist that includes two hourly checks when an enabler or restraint is in use. There is an improvement required around documentation of risks associated with the use of enabler on assessment and clear differentiation between a restraint and enabler.

Three family/whanau advised on interview that they are involved in the development of the care plan and kept well informed of changes to care or health status and support by staff is consistent with their expectations. A courtesy call is made to the family monthly which allows for open discussion including any concerns the relatives may have regarding their family members health.

D18.3 and 4; Dressing supplies are available and there are adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

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

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

Attainment and Risk: PA Low

Evidence:

Wound assessments and treatment plans including the frequency of evaluations and dressing changes are in place for 30 wounds (includes 10 skin tears and seven pressure areas). Evaluations and dressing changes are carried out at the required timeframe. A range of assessment tools available for completion on admission are (but not limited to); a) min nutritional assessment and dietary profile b) waterlow pressure area risk assessment, c) continence management plan d) FRAT falls risk assessment e) pain assessment f) wound assessment and g) depression scale. Consents and assessments are completed for the use of restraints and enablers. Healthcare assistants sign the monitoring checklist that includes two hourly checks when an enabler or restraint is in use.

Finding:

1) Twenty nine out of thirty wound assessments are not dated or signed by the assessor. 2) One rest home resident recently admitted with high falls risk does not have a falls risk assessment completed. The same resident has a pain assessment in place however the type of pain or location is not identified on the pain assessment or initial assessment. 3) One hospital resident (frequent faller) has not had a post falls assessment following two falls over two consecutive days as per policy. 4) Risks associated with use of enablers/restraints are not identified in the care plan. There is clear differentiation required on documents between an enabler and restraint in use.

Corrective Action:

1) Ensure wound assessments are dated and signed by the assessor. 2) Ensure risk assessments are completed on admission and with risk assessments changes. 3) Ensure post falls assessments are completed as per policy 4) Ensure risks associated with the use of enablers/restraints are identified on the 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

Attainment and Risk: FA

Evidence:

The service employs three activity co-ordinators. The hospital co-ordinator works 20 hours per week and has commenced diversional therapy (DT) training. The rest home co-ordinator works 35 hours and has completed the ACE advanced course and dementia units. A third activity co-ordinator is currently being orientated to cover one week day and the weekends in the rest home and the hospital unit. The activity co-ordinators have access to a qualified DT assessor with networking opportunities. Activity co-ordinators attend on-site in-service. The programme is planned a month in advance and there are copies (including large print) displayed and available to the residents. There are separate programmes for the rest home and hospital units that meets the physical, intellectual, social and spiritual needs of the residents. The activities in both units are open to all residents allowing a choice of activity to attend. Attendance at activities are voluntary. The activity co-ordinators make daily contact with residents who are unable to participate in activities or choose to stay in their rooms. One on one time with residents includes discussions, reminiscing, hand massages an individual activities. Residents are encouraged to maintain community links such as coffee clubs and the Howick club. Community visitors include school children, entertainers, visiting pets, wind instrument groups and choirs. There are interdenominational church services on Sundays and Catholic communion weekly on Fridays.

Activities take place in the rest home and hospital lounges and activities centre. Activities include (but not limited to); board games (bingo, snakes and ladders), trivia quizzes, Tai Chi, sit dancing, newspaper reading, walking group, foot spas, nail care, lawn bowls, and crafts, knitting and crochet.

Resident meetings and surveys provide residents with an opportunity to feedback on the activity programme. Festive and religious occasions are celebrated such as Easter, Christmas, resident birthdays, St Patrick's Day. The service has access to a wheelchair van for weekly outings that include scenic drives, picnics etc. The driver and escort are provided from another CHT facility.

Residents and the family are involved in the development of the care plan which includes activities, cultural and spiritual needs and preferences. The activity co-ordinators maintain an individual activity attendance sheet. Residents and relatives interviewed are satisfied with the content and variety of the activity programme.
D16.5d. The review of the activity plan and care plan occurs at the same time.

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 assessments and initial care plans are developed by a RN within 48 hours of admission. The long term care plan is developed within three weeks of admission (in six of seven files) and evaluated at least six monthly (in five of seven files) or if there is a change in health status. One rest home resident is not due for a three week long term care plan and one hospital resident has not been at the service six months for an evaluation of the long term care plan. There are six monthly written reviews. Changes are written into the V-care long term care plan as they occur.

There is a three monthly review by the GP. There is documented evidence that care plan evaluations are up to date in five of seven resident files sampled. Care plan reviews are signed as completed by an RN. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled.
D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated.

ARC: D16.3c; Initial care plans are evaluated by the RN within three weeks of admission for six of seven files sampled. One rest home resident is not due for three week evaluation of the initial care plan.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy is contracted to provide the medication robotic rolls packs and other pharmaceuticals. The RN checks the regular medications on delivery and signs the first and last robotic sachet. PRN medications are dispensed in bottles and kept in locked drawers (accessible to RNs only) in the hospital residents rooms. PRN medications for rest home residents is kept in the drug trolley. PRN medications are dispensed three monthly or earlier if required. Pharmacy order forms are maintained. RNs and HCAs responsible for administering medications complete annual medication competencies including insulin and controlled drug competencies. RNs complete syringe driver competencies and refreshers (on-line Nikki T). Annual medication education is attended. Self-medicating residents receive a fortnightly pack which is signed as checked by the RN. Daily monitoring occurs with signing on the administration sheet. The medication chart identifies residents who are self-medicating. Self-medicating residents are assessed and there is a RN and GP review three monthly of the resident's ability to self-medicate. Standing orders are not used. Controlled drugs are stored in a safe within the keypad medication rooms (rest home and hospital). The hospital unit holds hospital controlled drug stock and imprest stock for liverpool care pathway. RNs only have access to the controlled drug key. There are weekly controlled drug checks and six monthly pharmacy audits. Medication fridge monitoring is checked and recorded weekly. The hospital medication fridge is kept locked when syringe drivers are being stored in the fridge. All eye drops have been dated on opening. Checklists are maintained for oxygen, suction and oxygen concentrators.

All signing sheets are completed correctly. This is an improvement from the previous audit. Staff signatures are sighted on the medication signing register. PRN medications include date and time of administration on the signing sheet. Supplements have signing sheets. There are special instructions for medication administration as required, duplicate name labels, controlled drug alerts. Medication administration is observed in the rest home and complies with medication policy and protocol. Medication charts are pharmacy generated.

Twelve medication charts sampled (six hospital, six rest home) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. All 12 medication charts evidenced three monthly GP reviews. There is an improvement required around the indication for use for PRN medications.

D16.5.e.i.2; Twelve out of 12 medication charts reviewed identified that the GP had seen and 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: PA Low

Evidence:

PRN medications include date and time of administration on the signing sheet. Supplements have signing sheets. There are special instructions for medication administration as required, duplicate name labels, controlled drug alerts. Medication administration is observed in the rest home and complies with medication policy and protocol. Medication charts are pharmacy generated.

Twelve medication charts sampled (six hospital, six rest home) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. All 12 medication charts evidenced three monthly GP reviews.

Finding:

Four out of 12 medication charts reviewed did not have indications for use for PRN medications.

Corrective Action:

Ensure all PRN medications have an indication for use prescribed on the medication chart.

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.

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:

Medirest is contracted to provide meals. All meals are prepared and cooked on-site. There is a qualified chef and two kitchen hands on duty daily. There is a four week menu cycle in place that can be adapted to feedback received from resident food surveys, such as scones on Fridays. The winter menu has been reviewed April 2014. Dietary profiles are completed on resident admission and reviewed six monthly with copies held in the kitchen. Dislikes and dietary requirements are written on the kitchen whiteboard. Diets provided are normal, puree, mince and moist and diabetic. Fortified foods are prepared for residents on the REAP programme. The chef is notified of any residents with weight loss or dietary requirements. Snacks are readily available for residents as required outside of kitchen hours. A recent quality initiative in progress is for the provision of finger foods. Trolleys are used to deliver meals plated with heat lids to the hospital dining area and rooms and to the rest home dining room in scan boxes.

Lip plates and specialised utensils are provided for residents as assessed. Hot food temperatures, walk-in chiller, freezer and dishwasher temperatures are checked and recorded daily (records sighted). All foods sighted in fridges and freezers are dated. Dry goods in the pantry are sealed, dated, labelled and off the floor. The kitchen is well equipped with a separate dishwashing area, food preparation and cooking, storage and delivery areas. There is combioven and electric cooking appliances. A cleaning schedule is maintained. The most recent kitchen cleaning audit was 98%. Corrective action (cleaning of the fan) has been completed. The fire blanket and fire extinguisher has been checked October 2013. Staff are observed wearing correct protective wear, hats, aprons and gloves.

Medirest services at Lansdowne have been awarded Medirest Environmental site of the year for the second consecutive year.

D19.2 ; Staff have been trained in safe food handling.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The facility holds a current warrant of fitness which expires on 4 March 2015.

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

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 policy identifies that restraint is used as a last resort. The service currently has one resident who have been assessed as requiring the use of a restraint (bedrails). There are seven enablers in use (six bedrails and one lap belt). A monthly restraint and enabler register is maintained.

Restraint minimisation and safe practice policies and procedures are in place. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies such as behaviour monitoring, sensor mats, ultra low beds and floor mattresses have been ineffective. Restraint minimisation policies and procedures include definitions, processes and uses of restraints and enablers.

Enablers are voluntary and the least restrictive option. The restraint register has documented one residents using a restraint (bedrails only) and seven residents using enablers (six bedrails and one lap belt). The enrolled nurse is the restraint co-ordinator with a job description in place with defined responsibilities for restraint/enablers. Clinical staff receive orientation in restraint/enablers and ongoing education. Staff complete ACE Dementia module seven. Organizational Restraint co-ordinators attend annual meetings/education at head office. Restraints/enablers are a set agenda item at the staff meetings. The restraint co-ordinator reports to the Quality meetings two monthly.

The files of the two residents using enablers and one resident using a restraint were reviewed. Evidence of an assessment and consent for the use of bedrails (2) and one lap belt was evidenced in the three residents' files. Alternatives are explored prior to the implementation of restraint as part of the assessment process. All residents using a restraint or enablers are monitored a minimum of two-hourly for safety. Three residents' care plans reviewed are required to include the risks associated with the use of restraint or enabler (link 1.3.6.1).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Standard 3.5: 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:

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly report completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at both the infection control and health & safety meetings (bimonthly) and the quality meetings (bimonthly). The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme and is part of the six monthly audit process. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The last outbreak was in February (2014) – gastroenteritis – affecting a total of 31 (of 95) residents and lasted two weeks. The information reviewed demonstrates effective minimisation of spread and resolution.

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.)*