Windsor House Board of Governors

Current Status: 1 July 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification 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

Windsor Care provides rest home, hospital and dementia specific level care for up to 80 residents with full occupancy on the days of audit. There were 19 residents requiring rest home level care, 41 requiring hospital care and 20 residents requiring the dementia unit. The service continues to implement a quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced general manager who is supported by a clinical manager (registered nurse) and a support services manager. Registered nurses are on duty on each shift. The general manager reports that staff turnover is low.

The service continues to provide care to residents based on the services mission and philosophy of care. Staff interviewed and documentation reviewed identified the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified no shortfalls or improvements required.

Audit Summary as at 1 July 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 1 July 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 1 July 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 1 July 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.

Safe and Appropriate Environment as at 1 July 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 1 July 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 1 July 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.

Audit Results as at 1 July 2014

Consumer Rights

Windsor Care's philosophy is to provide a safe and caring home environment which respects the uniqueness and fosters the potential of each individual resident. The health and disability commissioner (HDC) code of health and disability services consumers' rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

Organisational Management

Windsor Care has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to two monthly staff and quality meetings and monthly health and safety meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at four monthly meetings (six monthly for hospital) and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Windsor Care has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training

programme that has been implemented and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs

Continuum of Service Delivery

Residents and families receive an informative information pack that describes the facility and provision of service including dementia specific information. Service delivery plans demonstrate service integration. Assessments and care plans are completed by the registered nurses. Short term care plans are utilised for changes in health status such as infections and wounds. Care plans are goal oriented and reviewed at least six monthly. Residents and family interviewed described being involved in the care planning process and they were informed of any changes in health care status. Multi-disciplinary team meetings take place for each resident. Referral to other health and disability services is evident in a sample group of resident files. Activities are varied, meaningful and include inclusion at local community and entertainment events. Activity plans contain goals and interventions to assist residents to reach the desired outcome. The diversional therapist in the dementia unit provides a structured and individualised plan for the residents across 24 hours. The rest home and hospital programme is also comprehensive and involves the wider community. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are reviewed by the general practitioner three monthly or earlier if necessary. Medications were observed to be managed and administered appropriately. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. There are food service policies and procedures and a link to a dietitian. All food is cooked on site and residents interviewed were very complimentary of the variety and choice of food available on the menu.

Safe and Appropriate Environment

Windsor Care has a current building certificate that expires on 1 January 2015. Maintenance is carried out. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. In each unit there is a lounge and dining area, and small seating areas throughout the wings. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged to allow residents to mobilise. There is a large designated laundry which includes storage of cleaning and laundry chemicals. Hot water temperatures are monitored and recorded. Communal living areas and resident rooms are appropriately heated and ventilated. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved

evacuation scheme and emergency food and water supplies for at least five days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence supply room and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Restraint Minimisation and Safe Practice

On the day of audit there were 18 residents assessed as requiring restraint and a resident with an enabler. Restraint includes bedrails and lap belts, which are utilised as falls prevention measures and for resident's personal safety. Staff attend restraint minimisation and safe practice education and complete competencies. A restraint register is maintained and appropriate documentation is recorded for assessment, consent, planning and monitoring of restraint. The restraint minimisation programme is reviewed six monthly.

Infection Prevention and Control

The infection control coordinator is a unit manager and registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually by the facility's infection control committee. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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:	Windsor House Board of Governors
Certificate name:	Windsor House Board of Governors

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit			
Premises audited:	Windsorcare			
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care			
Dates of audit:	**Start date:**	1 July 2014	**End date:**	2 July 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:	80

Audit Team

Lead Auditor	XXXXXXX	**Hours on site**	15	**Hours off site**	6
Other Auditors	XXXXXXX	**Total hours on site**	15	**Total hours off site**	4
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXXX			**Hours**	3

Sample Totals

Total audit hours on site	30	Total audit hours off site	13	Total audit hours	43

Number of residents interviewed	11	Number of staff interviewed	12	Number of managers interviewed	6
Number of residents' records reviewed	10	Number of staff records reviewed	11	Total number of managers (headcount)	6
Number of medication records reviewed	20	Total number of staff (headcount)	109	Number of relatives interviewed	12
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXXXXX, 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	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 7 August 2014

Executive Summary of Audit

General Overview

Windsorcare provides rest home, hospital and dementia specific level care for up to 80 residents with full occupancy on the days of audit. There were 19 residents requiring rest home level care, 41 requiring hospital care and 20 residents requiring the dementia unit. The service continues to implement a quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced general manager who is supported by a clinical manager (registered nurse) and a support services manager. Registered nurses are on duty on each shift. The general manager reports that staff turnover is low. The service continues to provide care to residents based on the services mission and philosophy of care. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified no shortfalls or improvements required.

Outcome 1.1: Consumer Rights

Windsorcare's philosophy is to provide a safe and caring home environment which respects the uniqueness and fosters the potential of each individual resident. The health and disability commissioner (HDC) code of health and disability services consumers' rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

Outcome 1.2: Organisational Management

Windsorcare has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to two monthly staff and quality meetings and monthly health and safety meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at four monthly meetings (six monthly for hospital) and via annual satisfaction surveys. There is a reporting process being used to

record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Windsorcare has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs

Outcome 1.3: Continuum of Service Delivery

Residents and families receive an informative information pack that describes the facility and provision of service including dementia specific information. Service delivery plans demonstrate service integration. Assessments and care plans are completed by the registered nurses. Short term care plans are utilised for changes in health status such as infections and wounds. Care plans are goal oriented and reviewed at least six monthly. Residents and family interviewed described being involved in the care planning process and they were informed of any changes in health care status. Multi-disciplinary team meetings take place for each resident. Referral to other health and disability services is evident in a sample group of resident files. Activities are varied, meaningful and include inclusion at local community and entertainment events. Activity plans contain goals and interventions to assist residents to reach the desired outcome. The diversional therapist in the dementia unit provides a structured and individualised plan for the residents across 24 hours. The rest home and hospital programme is also comprehensive and involves the wider community. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are reviewed by the general practitioner three monthly or earlier if necessary. Medications were observed to be managed and administered appropriately. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. There are food service policies and procedures and a link to a dietitian. All food is cooked on site and residents interviewed were very complimentary of the variety and choice of food available on the menu.

Outcome 1.4: Safe and Appropriate Environment

Windsorcare has a current building certificate that expires on 1 January 2015. Maintenance is carried out. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. In each unit there is a lounge and dining area, and small seating areas throughout the wings. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged to allow residents to mobilise. There is a large designated laundry which includes storage of cleaning and laundry chemicals. Hot water temperatures are monitored and recorded. Communal living areas and resident rooms are appropriately heated and ventilated. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved

evacuation scheme and emergency food and water supplies for at least five days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence supply room and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Outcome 2: Restraint Minimisation and Safe Practice

On the day of audit there were 18 residents assessed as requiring restraint and a resident with an enabler. Restraint includes bedrails and lap belts, which are utilised as falls prevention measures and for resident's personal safety. Staff attend restraint minimisation and safe practice education and complete competencies. A restraint register is maintained and appropriate documentation is recorded for assessment, consent, planning and monitoring of restraint. The restraint minimisation programme is reviewed six monthly.

Outcome 3: Infection Prevention and Control

The infection control coordinator is a unit manager and registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually by the facility's infection control committee. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	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	0
Criteria	0	0	0	0	0	0	0	0

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

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 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

There is a code of rights policy. On interview all staff - nine caregivers (one rest home, three dementia and five hospital), one enrolled nurse (dementia), four registered nurses (RN's), one clinical manager, two unit managers, one quality manager and one general manager were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of Rights is discussed at four monthly resident/relatives (six monthly for hospital) and two monthly staff meetings. Eleven residents (seven rest home and four hospital) and twelve family members (two rest home, six hospital and four dementia), interviewed spoke highly of the staffs respect of all aspects of the code of rights. Code of rights, advocacy, privacy and informed consent training was held in June 2014.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

There are posters of the code of rights on display throughout the facility and leaflets in the foyer and hospital area of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all staff (nine caregivers, one enrolled nurse, four RN's, one clinical manager, and two unit managers) stated that they take time to explain the rights to residents and their family members. Eleven residents (seven rest home and four hospital) and12 family members (two rest home, six hospital and four dementia) confirmed that they had received information about their rights on entry to the service.

Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the clinical manager, unit mangers or an RN discuss the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy. On interview 11 of 11 residents and 12 of 12 family members were able to state their understanding of the code of rights.

Health and disability advocacy service leaflets are on display on the notice board in the foyer and throughout the facility. The service can access local Maori advisory services should this be requested. Education on advocacy services is provided in the facility and this was last held in June 2014.

The information pack provided to residents on entry includes how to make a complaint, informed consent, code of rights, interpreter services, advocacy and H&D Commission information

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention 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.)*

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA

Evidence:

Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All 11 residents and 12 family members interviewed indicated staff were highly respectful and maintained resident's privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training was last held in June 2014.

The resident's initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All 11 residents interviewed stated their needs were met. All 10 resident files reviewed (three rest home, four

hospital and three dementia unit), have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.

There is a policy that describes resident's spiritual care. There are various churches locally and residents are encouraged to attend these. Multidenominational services are conducted in the facility at least once a week. The service has access to a Chaplain who blesses the rooms. All residents and family members interviewed indicated that resident's spiritual needs are being met when required. On interview all 11 residents (seven rest home and four hospital) stated staff respect their rights. The service includes emotional wellbeing in the care planning process.

Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered and discussed openly. On interview all 11 residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all nine caregivers described how they encouraged residents to engage in activities in the facility and to link with community activities including church and support groups.

There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff in-service training held in April 2014. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. 11 residents and 12 family members interviewed were complementary of the care provided and stated staff were very caring, approachable and friendly.

The service has a philosophy that respects the uniqueness and fosters the potential of each individual resident, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

Four of four families from the dementia unit state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

Resident files reviewed identified that cultural, spiritual values and individual preferences are identified

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

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 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes 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 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA

Evidence:

The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures.

Staff training includes cultural safety at orientation. Cultural safety in-service training was last held in September 2013. There are currently no residents who identify as Maori. Windsorcare identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the RN's, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual's service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with four RN's, one enrolled nurse, one clinical manager, two unit managers, nine caregivers and

one general manager confirm that they are aware of the need to respond to cultural differences . On interview all staff were able to identify how to obtain support so that they could respond appropriately. There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e) of the ARC contract. The service has developed a link with local Maori organisations and iwi (Ngai tahu).

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with 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.)*

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported 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.)*

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. All residents currently at the service are English speaking.

Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.

The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs

Care plans reviewed included the resident's social, spiritual, cultural and recreational needs

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

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 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The facility has a policy that determines a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover physical, psychological and emotional abuse and cultural abuse. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and as part of code of rights training and includes professionalism and standards of conduct. Codes of rights in-service training was last held in June 2014 and abuse and neglect in-service training was last held in April 2014. The Unit Managers and RN's supervise staff to ensure professional practice is maintained in the service.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation, employee agreement and staff handbook provided to staff on induction includes Windsorcare values and beliefs and outlines accepted standards of conduct

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being 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.)*

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete Aged Care Education programme NZQA level training and an internal in-service training programme is implemented. The general manager, clinical manager, unit managers and support services manager attend external training sessions appropriate for their positions.

Services are provided at the facility that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. All approved service standards are adhered to. There are implemented competencies for RN's and EN's. There are clear ethical and professional standards and boundaries within job descriptions

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 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:

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Twelve incidents/accidents forms were viewed for May 2014 (two rest home, six hospital and four dementia). The forms include a section to record family notification. All family were informed. There are family contact sheets in front of each residents file. Windsorcare has an open disclosure policy. On interview 11 residents (seven rest home and four hospital), 12 family members (two rest home, six hospital and four dementia) all stated that family are informed following changes in the resident's health status.

Two unit managers, one clinical manager, four registered nurses and one enrolled nurse interviewed stated that they record contact with family/whanau in resident's files. Contact records were documented in all 10 resident files reviewed.

A residents/relative meeting occurs four monthly (six monthly for hospital) and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.

There is a policy that describes the availability of interpreter services when required.

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.

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.

The information pack is available in large print and advised that 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): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Windsorcare has policies and procedures relating to informed consent. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Caregivers (nine) and registered nurses (five) interviewed are familiar with the code of rights and informed consent and described the link between the home's philosophy and choice and consent on a daily basis. Informed consent forms are evident on 10 of 10 resident files reviewed (three rest home, four hospital and three dementia). There is a resuscitation policy and resuscitation decision form that is completed appropriately for 10 of 10 resident files reviewed in consultation with the resident, activated EPOA, registered nurse (RN) and general practitioner (GP). Admission agreements were signed and evident in 10 of 10 files reviewed. Discussion with 12 family members identifies that the service actively involves them in decisions that affect their relative's lives.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

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

The service is able to demonstrate that written consent is obtained 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

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

Attainment and Risk: 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 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA

Evidence:

There is an advocacy policy. Staff receive training on advocacy services. Advocacy in-service training was last held in June 2014. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with nine caregivers, 11 residents and 12 family members informed they are aware of advocacy and how to access an advocate.

Discussion with12 family members (two rest home, six hospital and four dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions. There is a multi-disciplinary meeting held six monthly for each resident with family involvement.

The resident file includes information on resident's family/whānau and chosen social networks.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

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 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff (nine caregivers, one enrolled nurse, four registered nurses, one clinical manager, two unit managers and the general manager) stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this. The facility engages with other local facilities that provide similar services. Discussion with 12 family members stated that they are encouraged to be involved with the service and care.

Discussion with all staff (nine caregivers, one enrolled nurse, four registered nurses, one clinical manager, two unit manages and the general manager) and 12 family members (two rest home, six hospital and four dementia), confirm that they are supported and encouraged to remain involved in the community and external groups such as churches, schools, kindergarten and the local shopping mall.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when 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 1.1.13: 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 service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about the complaints process is provided on admission. Interview with11 residents (seven rest home and four hospital) and12 family members (two rest home, six hospital and four dementia) inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints

There is a complaints register. The service has received four complaints since January 2014. These included call bell response times, staff talking too loud on night shift, food likes and dislikes and heating in resident's rooms (DHB involvement). All complaints were sighted as resolved. Verbal and written complaints are documented when received. All complaints are recorded in the complaints register. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.

Discussions with 11 residents and 12 family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with nine caregivers stated that concerns/complaints would be discussed at two monthly staff meetings and meeting minutes available in the staff room.

A complaints procedure is provided to residents within the information pack at entry.

There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, behaviour management and the complaint policy.

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:

Windsorcare is a purpose built facility that has completed a major rebuild project over the last few years and is now fully completed. The services occupy the two story building with hospital, rest home and secure dementia rest home residents. Windsorcare has recently undergone a branding change from Windsor House to Windsorcare E. Windsorcare is the trading name for the Windsor House Board of Governors, a charitable trust, managed by a general manager reporting to the board. Currently there are eight board members. The general manager meets with the chair- person of the board weekly and formally reports to the board at monthly meetings. The service can provide care for 80 residents. On the day of the audit the service was fully occupied with 80 residents (19 rest home, 41 hospital and 20 dementia). The service has one rest home/hospital dual bed.

Windsorcare has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The current strategic plan includes four broad service goals relating to, quality people and quality resources, quality services, sustainability (financial and governance) and active, visible and vocal (positive profile in the community). The service mission statement states; “providing a safe and caring home environment which respects the uniqueness and fosters the potential of each individual resident”. Core values and behaviours include: individuality and independence, dignity, connection, we value staff, quality, improvement and prudence. The annual quality plan includes an audit plan, education plan, incident and accident reporting, with an analysis completed monthly for the quality meeting.

The quality process being implemented includes regular review of policies, an internal audit programme and a health and safety programme that includes hazard management. Two monthly staff meetings and two monthly quality meetings discuss key components of the quality system and any issues are reported (minutes viewed). There is an internal audit schedule that aligns with the business/strategic plan and is implemented and a corrective action plan used to manage shortfalls. The general manager has been employed at the service for 15 months and is suitably qualified with a background in law, health and disability management, insurance and banking. The general manager is supported by the clinical manager, support services manager and quality manager. The senior team has recently been strengthened by the introduction of two unit managers to provide more training, mentoring and support for staff and residents and their families.

Windsorcare undertakes external certification for ACC workplace safety management practices for employee health and safety (expires 30 November 2015) and is also certified under the hazard analysis critical control point (HACCP) food safety programme (expires 30 November 2014).

The philosophy of the organisation includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused state.

The general manager is suitably qualified and is supported by a clinical manager, support services manager and quality manager. The general manager has attended a three day aged care conference and an elder law conference in the past 12 months.

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 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

In the absence of the general manager the clinical manager and the support services manager oversees the management of Windsorcare. A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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 facility has a quality framework that is being implemented. The general manager is directly involved in operations at the facility and the clinical manager, support services manager, quality manager and two unit managers support the general manager in this role. The service has a manager employed eight hours per week to manage the quality and risk programme. There is a current business/strategic plan that includes objectives/goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. The current quality and risk management plan objectives 2014 include (but are not limited to); audit compliance, restraint minimisation and safe practice, policy and procedure reviews, professional development, security, cultural awareness, consumer rights and human resources. There is a continuous quality improvement register which documents all quality improvements identified with interventions and expected dates of completion including (but not limited to); signage, work experience programme, building repairs, uniform review, quality management, the introduction and training of physiotherapy aids to increase the mobility/prevent falls of residents throughout the facility, roster review, restructure of clinical leadership, introducing the Windsorcare way, security review and rebranding. A number of CQI's have a specific resident focus where Windsorcare can demonstrate measurable improvements in outcome – for example, toolbox talks and education sessions at staff handovers have focused on skin tear prevention and skin integrity best practice resulting in a measurable downward trend in skin tears throughout the facility. A staff member was trained in chest percussion and supervised by an experienced physiotherapist to provide daily chest physiotherapy as clinically indicated to improve the quality of life of that resident. The purchase of a number of high/low electric beds to minimise the risk of falls and the use of restraint (bedrails). In addition, at significant cost, the Trustees resolved to purchase a new generator to provide full power to the entire site in the event of *any* disruption to power supply – this provides business continuity and has eliminated any significant disruption to the care and delivery of services offered across the whole site. Interview with all staff (nine caregivers, one enrolled nurse, four registered nurses, one clinical manager, two unit managers, and one quality improvement contractor and the general manager, inform an understanding of the quality activities undertaken at Windsorcare

Resident/relatives meetings occur four monthly (six monthly hospital), minutes viewed. 11 of 11 residents interviewed are aware meetings are held. Annual satisfaction surveys are undertaken. The last satisfaction survey was April 2013 and feedback as sighted was overall positive about the service. The service is currently undertaking a satisfaction survey for 2014. A GP satisfaction survey was conducted in May 2013 with overall positive results from the 10 GPs that responded. A staff survey is scheduled for September 2014 to include feedback about the roster changes and other quality improvements. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit, resident and relative feedback indicated satisfaction with the service.

Policies and procedures are in place with evidence of review. The general manager, quality manager and the senior management team manage quality systems. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff meetings and quality meetings. Meetings discus key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. The service uses the Joanna Briggs Institute Policies for aged care. Procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked cupboard.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed monthly. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented.

There is a 2014 internal audit programme which includes (but is not limited to); hand hygiene (January), consumer rights (February), laundry services (March), contractors health & safety (March), restraint (April), first aid kits (April), clinical records (April), medication management (May) and infection prevention (June). The 2013 audit programme was also reviewed. Corrective actions were documented and sighted as resolved. Results of audits are discussed in quality and staff meetings.

Monitoring data that is collected by way of monthly incident report, infection collation, and outcomes from internal audits are reported through to quality and staff meetings. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been regularly completed and documented in the quality/staff meeting minutes. All staff interviewed could describe the corrective action process. The facility's monitoring activities, link to the means of achieving objectives as outlined in the quality programme. Copies of the quality meeting minutes were viewed in a folder available for employees to read. In addition, each area has meetings relevant to the service provided with records viewed for rest home meetings in February and April 2014. The dementia rest home meeting minutes were viewed for January, March and May 2014. Hospital meeting minutes were viewed for January, March and May 2014. The general manager meets with the chairperson of the board weekly and provides a written report and meets monthly with the full board.

Windsorcare has policies and procedures that describe the management of risks. There is a hazard register that is reviewed monthly. Hazard forms are available for use and are seen to be well utilised. Nine caregivers interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk. Falls prevention strategies such as the use of sensor pads and falls risk assessments and use of standing hoists are in place. There is a hazard register that is reviewed monthly. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the unit managers, clinical manager and general manager who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the health and safety, staff and quality and risk meetings. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. A sample of 12 incidents/accidents from January to April 2014 were viewed (two rest home, six hospital and four dementia) which included four falls, two potential falls, three behaviours, one skin tear, one medication error and one other. The facilities policy and procedure on incident management was implemented. Residents (seven rest home and four hospital) and relatives (two rest home, four

dementia and six hospital) interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. Copies of relevant incident forms are held in the clinical files. All adverse events are analysed monthly and included in the quality meetings. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

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:

Windsorcare employs 109 staff, the majority of whom work part time. There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificates of registered nurses and enrolled nurses are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist, dietician, podiatrist and physiotherapist. Appointment documentation is seen in 12 staff files sampled (one clinical manager, one unit manager, two registered nurses, three caregivers, one cook, one DT, one maintenance/gardener, and two cleaner/laundry) including signed contracts, job descriptions, orientation, practicing certificates, reference checks and training. There is an annual appraisal process in place and appraisals are current in all files reviewed.

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with nine caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the general manager. The service has a training policy and schedule for in-service education. The in- service schedule is implemented and attendance records at sessions kept. The quality manager is accountable for managing and delivering the training schedule. Records were viewed for attendance for 2013-2014 including but not limited to: fire safety 32, after death care 16, chemical training 19, infection prevention 19, elder abuse and neglect 22 and restraint minimisation 17. Interview with nine caregivers inform there is access to sufficient training. The annual training programme exceeds eight hours annually. Medication competencies are required to be completed for all registered nurses (RN)'s, enrolled nurses (EN)'s and senior care staff who administer medication. Registered nurses also complete two yearly syringe driver training and competency. One RN is also trained and competent in replacement of a PEG feed tube.

Staff employed to work in the dementia unit receive an orientation programme which is relevant to the dementia unit and includes a session on how to implement activities and therapies. Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. The organisation works with the agency to ensure where possible the same agency staff return to the same service within the facility. The service has actively reduced the use of agency staff as part of the service's quality improvements. There are 12 caregivers who work in the dementia unit. Nine of these caregivers have completed ACE dementia standards and three are currently completing ACE dementia.

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. Rosters are arranged on a four weekly basis, with separate rosters for the hospital, rest home and secure dementia rest home. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the clinical manager, support services manager or the general manager will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The clinical manager and support services manager cover the general manager during absences and holidays. Residents and relatives interviewed stated they felt there are sufficient staff to meet the needs of residents.

There is an RN on duty 24 hours per day.

A contractor physiotherapist attends the facility for two hours a week and three caregivers are trained as physiotherapist's assistants.

Management roles are made up of general manager 40 hours per week, clinical manager 72 hours per fortnight (general oversight of all clinical staff), support services manager 40 hours per week (general oversight of all support services staff), quality manager 8 hours per week and two unit managers 40 hours each per week.

In the hospital unit there is a registered nurse on duty 24/7 who also provides cover for the rest home and dementia unit if the clinical manager, unit manager or the dementia RN/EN is not on duty. There are two RNs on am and pm and one RN on night duty. Other staff in the hospital unit on morning duty include four caregivers rostered for eight hours, two caregivers rostered for six hours and two caregivers rostered for five and a half hours. In the afternoon two registered nurses are rostered for eight hours, four caregivers for eight hours and two caregivers for four hours. In addition, there is an activities coordinator supervised by a registered diversional therapist who provides an activities programme four hours each day Monday to Friday to meet the specific needs of the residents in the hospital. The hospital night shift has a registered nurse rostered eight hours, and three caregivers for eight hours (one of which can assist rest home and dementia if required).

The dementia rest home has a registered nurse rostered for two days - Thursday and Friday with the balance of the week covered by an enrolled nurse. A senior caregiver is rostered for eight hours, two caregivers for eight hours and a further caregiver for four hours. The afternoon shift has a senior care giver rostered for eight hours, a caregiver for eight hours, a caregiver for seven 1/2 hours and a further care giver for four 1/2 hours. In addition, there is a registered diversional therapist rostered in the dementia rest home from 11 till 5pm Monday to Friday to enhance the activities programme and improve the quality of care offered to these residents. A caregiver is rostered for eight hours over the night.

The rest home has an enrolled nurse for one day (eight hours), a senior caregiver rostered for eight hours in the morning, a care giver for eight hours and a care giver for five and a half hours. The afternoon has an enrolled nurse rostered for eight hours, two days a week and a senior caregiver for the remaining

four days for eight hours. Two caregivers are rostered for seven and half hours. In addition, there is a registered diversional therapist rostered in the rest home each day Monday to Friday to enhance the activities programme and improve the quality of care offered to these residents. In addition, she has the responsibility of coordinating the activities of the volunteer team who provide activities throughout the facility. A caregiver is rostered for eight hours for the night.

Windsorcare also provides comprehensive support service staffing which includes cooks, catering assistants, laundry and cleaning personnel, maintenance, gardening and waste management staff available seven days a week and on-call as necessary.

All rosters allow for hand-over time. The rosters provide sufficient and appropriate coverage for effective delivery of care and support for the full facility. The service has actively reduced the use of bureau staff.

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:

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate). All resident files are hard copy files. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident's files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology Information in files is appropriate to the rest home, hospital and dementia service level setting. The service keeps a resident register.

Windsorcare has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy resident files are stored securely and protected from unauthorised access by being held at the locked nurses' stations. Old files are individually archived and locked in a secure area for 10 years.

Resident records are up to date and reflect residents' current overall health and care status. Records can be accessed only by relevant personnel.

Care plans and progress notes are legible, signed and dated by the staff member recording the information. Medical notes and allied health input are signed and dated appropriately. All nursing and progress notes entries are legible, dates and signed by an RN, EN or caregivers, including designation.

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

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

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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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 1.2.9.9 (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.)*

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and/or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. An information booklet is available to residents and families for the special care dementia unit which includes understanding behaviours, complaints process and restraint. Twelve relatives (two rest home, six hospital and four dementia) and eleven residents (seven rest home and four hospital) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the

service. Signed service agreements are evident in 10 of 10 resident files sampled (three rest home, four hospital and three dementia). The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The admission policy describes the declined entry to services process. Windsorcare records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency. The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative 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 1.3.3: 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 for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. The registered nurses at Windsorcare are responsible for development of the care plan with input from enrolled nurses and caregivers. Assessments are conducted and the initial care plan is developed within 24 hours of admission (10 of 10 resident files reviewed). Evaluations and reviews are completed by the registered nurse six monthly and includes a multi-disciplinary team meeting six monthly for each resident. These are conducted by a registered nurse with input from the care staff, diversional therapists, general practitioner (GP) and relatives, and occur to review all aspects of the residents care and support requirements. Re-assessments are completed at care plan review. The long term care plan is developed within three weeks of admission as evidenced in nine of ten care plans reviewed (one hospital palliative resident very recently admitted). Assessments include pressure area risk, falls risk, nutrition, pain, behaviour, mobility, continence and social and medical history. Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the care plan and at multi-disciplinary team meetings. Communication with family is documented on a family contact sheet or in the progress notes. A verbal and written handover occurs at the end of each shift. There is also a communication book.

Staff are informed of any care plans that have been updated at handover. Care plans are signed off by a registered nurse, the resident and/or family member. Medical assessments are completed within two working days of admission by the GP as evidenced in 10 of 10 files sampled (three rest home, four hospital and three dementia). It was noted in residents files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. On interview the GP stated that the service contacted him in a timely manner, providing information required to assess the residents. The service always carried out any observations and interventions as prescribed. The service has recently commenced using InterRAI and the clinical manager reports that six registered nurses have completed the training. Two of 10 resident files reviewed evidence that the interRAI assessment tool has been utilised (two rest home). Long term care plans reviewed for nine of ten resident's sampled evidenced comprehensive and resident focused goals and interventions. All 10 files identified integration of allied health.

Tracer Methodology Rest Home:

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

Tracer Methodology Hospital:

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

Tracer Methodology Dementia specific:

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:

Ensure that all residents have regular RN input that this is documented, and that RN's follow up all appropriate issues and document this in the resident file.

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

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

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

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

Attainment and Risk: FA

Evidence:

In 10 of 10 files sampled (three rest home, four hospital and three dementia), an initial nursing assessment and initial care plan was completed within 24 hours of admission. There are a range of assessments completed on admission and this includes skin, sleep patterns, language, speech, falls risk, dietary requirements, dietary management, pain, orientation, mental ability, mood, mobility, perception/sensory, social history, life history, sexuality/privacy, cultural/spiritual values and level of personal ability. The comprehensive assessment was completed in eight files reviewed - one rest home, four hospital and three dementia resident. Two rest home resident files evidenced that the interRAI assessment tool has been used to form the basis of the long term care plan. The assessment information gathered is used to plan resident goals and outcomes including communication, cognition/mood, personal hygiene, skin and wound care, mobility, eating and drinking, elimination, sleeping, psychosocial/cultural, pain, medication, behavioural, grief/death and dying, and restraint/enablers. Assessments are conducted in an appropriate and private manner. Residents and family members interviewed report being very satisfied with the support provided. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessments process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessments and care plans. Twelve relatives and eleven residents interviewed stated they were informed and involved in the assessment process. The assessment tools link to the individual care plans. The care plans are individualised for each resident need as detailed in the long term care plan. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.

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

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

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 1.3.5: Planning (HDS(C)S.2008:1.3.5)

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

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

Attainment and Risk: FA

Evidence:

The sample of 10 files reviewed included three rest home, four hospital, and three dementia residents. Each file contained resident information and admission data, family/next of kin/EPOA contact details, progress notes, long term care plan (nine of 10 – one recently admitted palliative care resident), medical records, lab results, physiotherapy/allied health notes, diversional therapy assessments, plan, 24 hour care plan, evaluation and progress notes, accident and incident summary and forms, consent and resuscitation decisions, admission agreement, needs assessment, EPOA documents (if applicable), interRAI assessment (if completed), and personal items list. The initial assessment and care plan identifies areas of concern or risk. Six registered nurses have completed the interRAI training and advised that the service has commenced utilising this tool for reassessing residents at Windsor. Two rest home resident files reviewed evidenced that the interRAI assessment tool has been completed. Resident's comprehensive long term care plans are individually developed with the resident and the family as evidenced in nine of ten files reviewed. Eleven residents and 12 family members interviewed stated they were involved in the care planning process. Nine of ten long term care plans reviewed were evidenced to be up to date and signed by either the resident or the next of kin. Nursing diagnosis, goals outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): communication, cognition/mood, personal hygiene, skin and wound care, mobility, eating and drinking, elimination, sleeping, psychosocial/cultural, pain, medication, behavioural, grief/death and dying, and restraint/enablers. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. There is evidence that the long term care plans were reviewed at least six monthly or when needs have changed. Nine of ten files reviewed evidenced that a diversional therapy plan has been developed, as well as a record of interests and activities over a 24 hour period. For dementia specific residents, there are detailed behaviour management plans and diversional activities for staff to implement. There is evidence that the residents are seen by the GP at least three monthly. The GP notes are well maintained.
Short term care plans are used for acute changes in health status. Examples sighted included infections, wounds, and decline in health status. Ten of ten files evidenced that family were involved – confirmed on interview with 12 family members (two rest home, six hospital and four dementia).

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

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

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 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

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:

Windsorcare provides services for residents requiring rest home, hospital care and dementia specific care. Individual care plans are completed. The nine caregivers (one rest home, three dementia, five hospital), one enrolled nurse from the dementia unit and four registered nurses interviewed stated that they have all the equipment referred to in the long term and short term residents care plans necessary to provide the care required. These include wheelchairs, walking frames, weighing scales, transferring equipment pressure relieving equipment, residents safety equipment, electric beds, continence supplies, gowns, masks, aprons and gloves. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There is a large well stocked treatment/medication storage room in the hospital area and a treatment/medication/nurses station in both the rest home and dementia unit.
There are currently five rest home residents with wounds, four dementia residents with wounds, 15 hospital residents with wounds, and three hospital residents with grade one and two pressure injuries. Wound assessment and management plans are documented for all wounds including ulcers, infected toes, skin tears, eczema, excoriations, skin lesions, bruising, scratches and surgical wound sites. The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Three residents are under the care of the diabetic clinic, vascular clinic and wound clinic. 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-service has been provided in July 2013 and wound management in-service has been provided in April 2013 and May 2014.
All falls are reported on the incident forms and reported to the registered nurse/unit manager//clinical manager/general manager. Falls risk assessment is completed on admission and reviewed six monthly or earlier should there be an increased falls risk. A physiotherapist works two hours per week and sees all new resident admissions. Physiotherapy plans are incorporated in long term care plans as required. Further referrals can be initiated as required and this was evidenced for one hospital resident.

There are registered nurses employed 24/7 by the service as well as a nurse unit manager who oversees the rest home and dementia unit, a nurse unit manager for the hospital, an enrolled nurse who is the dementia unit team leader and a Clinical Manager who oversees all clinical care of the residents. A record of all health practitioners practising certificates is kept. Resident's needs are assessed using pre admission documentation, doctor's notes and the assessments tools which are completed by the registered nurses. Care plans are goal orientated and reviewed six monthly. Care plans are updated to reflect intervention changes following review or change in health status.
During the tour of the facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents and relatives interviewed were able to confirm that privacy and dignity was maintained.

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

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

Attainment and Risk: 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 two qualified diversional therapists (DT) at Windsorcare who are responsible for the planning and delivery of the activities programme. One DT is responsible for the rest home residents (and retirement village cottage residents) and the other DT is responsible for the hospital and dementia unit residents activities programme. Both DT's work 37.5 hours each per week. They are assisted by an activities assistant who works 20 hours per week. Activities are held between 9am and 5pm. The diversional therapy team meet with the Clinical Manager once a fortnight to plan activities and discuss resident's needs and abilities. Each unit has its own activities programme and caters to the abilities and interests of the residents. Rest home resident's programme includes newspaper reading, exercises, housie, happy hour, bowls, games, picnics, concerts, drives and van outings. The hospital residents enjoy newspaper reading, exercises, happy hour, balloon tennis, housie, word find games and quizzes. There is joint entertainment provided and church services held in a large recreation room adjacent to the rest home dining room. The dementia unit programme includes exercises, ball soccer, balloon tennis, music, DVD's, crosswords, board games, happy hour, bingo, craft, baking, and knitting group. During the weekends, care staff in the dementia unit are provided with a programme of activities to conduct and have access to resources and supplies to meet the resident's needs. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after

admission obtaining a complete history of past and present interests and life events with family involvement. Of the ten files reviewed, nine resident's files (three rest home, three hospital and three dementia) evidenced that activity goals and plans were developed and reviewed at care plan review (one recently admitted palliative hospital resident excluded).
The programme also includes residents being involved within the community with social clubs, churches and schools. A record is kept of individual resident's activities and monthly progress notes completed. Participation in all activities is voluntary. The activity programme is displayed on the resident's notice boards and a copy is evident in every resident's room. Residents (11) and relatives (12) advised that the programme is interesting and varied and meets the resident's needs.
Windsorcare has its own van for transportation. The activity staff have current first aid certificates.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All initial care plans were developed by the registered nurse on the day of admission and residents comprehensive long term care plan developed within three weeks of admission (with the exception of the one palliative care hospital resident recently admitted). Long term care plans are evaluated six monthly or if

there is a significant change in health status. There was documented evidence that care plan evaluations were up to date in two rest home, two dementia and one hospital files sampled. A further one rest home, three hospital and one dementia resident had not been at the service for longer than six months. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by the registered nurse. There is at least a three monthly review by the medical practitioner or when requested if issues arise or health status changes. One GP interviewed stated that the communication from the service is appropriate and in a timely fashion and that the service carries out instructions. He advised that he has confidence in the skills and knowledge of the registered nurses and management team to safely care for residents. Short term care plans (STCP) were evident for current and previous wounds, skin tears and urinary tract infections. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

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 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

The four registered nurses, one enrolled nurse, two unit managers and one clinical manager described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, GP, dietitian, psychiatric services for the elderly and physiotherapist.
Discussions with the registered nurses and managers identified that the service has access to wound care nurse specialists, elder care needs assessment, palliative care team, incontinence specialists, diabetes clinic, speech language therapist, podiatrist and physiotherapist.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.
Progress notes document communication with family/EPOA regarding the transfer and updates on residents' condition.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

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: FA

Evidence:

The medication management system includes medication policy and procedures that follow recognised standards and guidelines for safe medicine management practice in accordance with the guidelines: 2011 medicines care guides for residential care.
The service has policies and procedures for ensuring all medicine related recoding and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo identification, allergies listed, with three monthly reviews of medication occurring by the GP. Windsorcare uses a four weekly blister pack system. Medication charts record prescribed medications by the residents' general practitioners and these are kept in the medication folders in each unit. The medication folders include specimen signatures for medication competent staff and GP's. There is a signed agreement with the pharmacy. Medications are delivered by the pharmacist and are checked on arrival by a registered nurse and recorded on a medication reconciliation form. Any pharmacy errors are recorded and fed back to the supplying pharmacy. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. The medication chart has alert stickers for allergies and duplicate names as evidenced in 20 medication files reviewed (six rest home, six dementia and eight hospital). Medication for use as required (PRN) is charted with reasons for giving documented. Management of warfarin, insulin, PRN controlled drugs and PEG feeds are all recorded appropriately.

Education on medication management occurred in March 2014. Registered nurse and senior caregiver competencies include blood sugar monitoring, controlled drugs, medication administration, and insulin administration. Registered nurses also complete two yearly syringe driver competency. A tracking process is in place to ensure competencies are completed and this is managed by the Clinical Manager. Two registered nurses in the hospital, one enrolled nurse in the dementia unit and one senior care giver in the rest home were observed administering medications safely – checking the medication chart against the medication pack, identifying the resident, observing the resident taking the medications and signing that they were given. In the rest home, either senior caregivers or an RN administer medications; in the dementia unit either an enrolled nurse or a registered nurse administer medications; and only registered nurses administer medications to hospital residents.

Medication charts have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and prn medication. There are no residents self-medicating at Windsorcare.
There are four medication trolleys, one in the rest home, and one in the dementia unit and two in the hospital unit. All are kept in locked treatment rooms. Controlled drugs for all residents are stored in a locked safe in the hospital unit pharmacy/treatment room which is also locked. Two medication competent persons must sign controlled drugs out – one of whom must be a registered nurse. There is evidence that a six monthly drug stocktake has been completed (three controlled drug registers sighted). Staff sign for the administration of medications on the medication signing sheet. There were no expired medications sighted in either the medication trolleys or the pharmacy/treatment room. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications.

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:

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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 1.3.12.5 (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:

Windsorcare has a large well equipped kitchen. All food is cooked on site. There is a food services manual that ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. A tour of the kitchen noted cleanliness and order in the pantry and fridges complying with guidelines. The service employs first and second cooks and kitchen hands. A head cook has completed unit standards 167 and all kitchen staff have completed food safety training, infection prevention education and safe chemical handling.

The food service has implemented a HACCP food safety programme with current certification (expires November 2014). All fridges and freezer temperatures are recorded daily on the recording sheet which was sighted. Food temperatures are recorded daily. Dish washer temperature is recorded monthly as part of the external checks undertaken by Ecolab. Dry food stuffs are stored in a storage area in the kitchen. All food was covered and stored on shelving above floor level. All meals are plated and covered and delivered to each area of the service at meal times

A nutritional profile for each resident is completed on admission and updated as required. A meal card is then developed for the individual regarding likes and dislikes, allergies, meal size and portions, with options for diabetic, pureed, soft, thickened fluids and vegetarian. There is an external provider dietician available for individual resident need. Menus are developed for summer and winter by the Head Cook in consultation with the HACCP representative and reviewed by the consultant dietician (May 2013). They are provided to residents on a six weekly cycle. Diets are modified as required. One hospital resident is receiving PEG feeds and the kitchen records show that residents who require them are receiving thickened fluids, and supplements. Staff were observed assisting residents with meals and drinks in the dementia unit and hospital unit. Eleven residents interviewed (seven rest home and four hospital) were very complimentary about the food provided and like the variety of the menu. Resident satisfaction survey which includes food was completed in April 2013 and showed overall satisfaction with the food service. Weights are monitored monthly or more frequently if indicated. Residents with weight loss issues receive nutritional supplements and food intake is monitored when required. The GP has requested that one hospital resident be weighed daily and this has occurred as evidenced in the file reviewed. There is evidence that there is additional nutritious snacks available over 24 hours in the dementia unit including sandwiches, fruit, biscuits and drinks. There is sufficient stores of food for emergencies for up to five days.

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 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There is an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Sluice rooms are locked. Bulk chemicals are stored in a locked storage room until required. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with the support services manager, nine caregivers, cleaning and laundry staff described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in March 2014.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used 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.)*

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 service displays a current building warrant of fitness which expires on 1 January 2015. The NZFS approved the fire evacuation scheme in August 2011. Scheduled and reactive maintenance is carried out and the service employs two maintenance personnel and one full time gardener. There are maintenance

books in each unit for staff to record requests from maintenance staff. These are reviewed daily and actioned. There is a hazard management plan and hazard registers in each area of service. Hot water temperature checks are conducted and recorded three monthly by the administration assistant as part of the audit plan. Hot water is provided via an LPG powered boiler (with a diesel boiler on standby if required) which provides hot water and heating throughout the facility. The service has standing and sling hoists, and chair scales which were last checked in May 2014. Oxygen concentrators and medical equipment was last calibrated and checked in June 2014. Two yearly testing and tagging of electrical equipment has been conducted. The interior is well maintained with a home-like décor and furnishings. Each unit at Windsorcare has a large communal lounge and dining area, with other small sitting areas. There is also a large recreation room for combined activities and meetings on the ground floor. There are small seating nooks available for residents and visitors. All rooms are large with wide corridors for easy access and residents were observed to mobilise safely throughout the facility. There is an external designated smoking area, however, there are currently no residents who smoke. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with nine caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. The dementia unit has a secure garden which residents can access from four doors and there is seating and shaded areas for residents to enjoy.

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.)*

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

Windsorcare underwent a significant rebuild in 2011. The building is purpose built to provide residential care for the elderly. The rest home wing has 20 resident rooms all with full ensuite, the hospital area on the first floor has 2 x 20 bed wings all with full ensuite, and the 20 bed dementia unit has shared and communal bathroom facilities. There are sufficient communal toilets and showers facilities within easy access of resident rooms. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Eleven residents (seven rest home and four hospital) interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene.
Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and vacant/in-use signs.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvred mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a large lounge and dining room in each wing with another large recreation room on the ground floor for combined meetings and activities. Other small seating nooks are in each wing. The dining rooms are spacious and allow sufficient room for staff to assist residents with their meals (meal times observed in all three service areas). All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and 11 residents interviewed report they can move around the facility and staff assist them if required.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to 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.)*

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

Windsorcare has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff attend infection control education and there is appropriate protective clothing available. Housekeeping staff are employed to attend to cleaning duties. Manufacturer's data safety charts are available. Eleven residents and 12 relatives interviewed report satisfaction with the laundry service and cleanliness of the rooms/facility. Resident satisfaction survey conducted in April 2013 included questions around laundry and cleaning with very positive comments and feedback reported. Laundry audits are conducted (March 2014) and a cleaning audit was last conducted in December 2013.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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

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

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

Attainment and Risk: FA

Evidence:

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the August 2011 following the rebuild of the facility. Fire evacuation drills have occurred six monthly - last conducted on 13 April 2014. Emergency preparedness in-service training was held in September 2012. Each area of the service has emergency management flip charts to direct staff in the event of emergencies. Civil defence emergency supplies cupboard is well stocked and checked regularly and is easily accessible to staff in an emergency. There is sufficient water stored and accessible in case of emergency. The facility has a large generator which was purchased in 2013 and provides full power to the entire site automatically should a power outage occur. There is also battery operated emergency lighting, extra torches, gas cooking and diesel and gas powered hot water and heating in use/available. Fire alarms and hose reels are checked by a contracted company. Testing and tagging of electrical appliances was last conducted in May 2014. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. The call bell system includes lights over the resident rooms and bathrooms and a lit panel in each corridor to identify in which room the assistance is required. Call bells were noted to be answered promptly. Security policies and procedures are in place. Advised by the support services manager that all external doors are automatically locked at dusk and staff also check that the facility is secure. The dementia unit is secure. Visitors can access the unit by activating a call bell for staff to open the door and staff have an electronic swipe card for accessing the unit. Windsorcare contracts an external security company who undertakes random security patrols across the site

three times each night. In addition, 24 hour surveillance cameras are strategically placed across the whole site to maximise security. These are monitored by the Support Services Manager.

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

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

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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation 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.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when 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 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated via an LPG powered boiler (with a diesel powered boiler as back up) and radiator system which can be controlled in each resident's room. Eleven residents and twelve relatives interviewed state the environment is warm and comfortable.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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:

Windsorcare has policies and procedures on restraint minimisation and safe practice. The quality manager is the current restraint coordinator at Windsorcare with the hospital nurse unit manager in the process of taking over this role. Both were interviewed.
Policy states that enablers are voluntary. There is one hospital resident using an enabler (wheelchair lap belt) and 18 residents assessed as requiring restraint (17 hospital and one dementia resident). Restraint in use includes bed rails (six), bed rails and lap belts (five), lap belts (five), and lap belt and hand holding (two – one hospital and one dementia). With the exception of the two residents with hand holding, the residents have restraint in situ as a falls prevention and safety measure. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers. The service is working towards decreasing the number of residents on restraint. The last review conducted in February 2014 saw two resident's restraint removed.
Documentation includes a restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. Restraint education was last provided for staff in May 2014 with an associated questionnaire and competency.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

Attainment and Risk: FA

Evidence:

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes key responsibilities for the restraint coordinator, who is also the quality manager. Restraint use is a regular agenda item in quality and health and safety meetings. Restraint use approval group meets six monthly (February 2014). Staff interviews confirm their understanding of using restraint only as a last resort, is used as a falls prevention measure and for resident and staff safety and security. Documentation includes restraint register, restraint assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms as evidenced in four hospital and one dementia resident files reviewed. Restraint education last provided for staff in May 2014. Staff have completed the restraint questionnaire and competency.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

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 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

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

Attainment and Risk: FA

Evidence:

Assessments are undertaken by the registered nurse in partnership with the GP, resident and their family/whanau. All restraint assessments are reviewed by the restraint coordinator as sighted in the four hospital and one dementia residents' files sampled. The one hospital and one dementia resident file reviewed recorded that hand holding is only used when the resident is physically aggressive during cares. This is recorded in the care plan, with times used monitored and recorded and only used as a last resort.
The five files sampled identified that restraint assessment has been conducted for all residents with restraint. Consent forms are completed for the residents requiring restraint.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

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 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The quality manager is the restraint co-ordinator. She advised that the hospital unit manager is due to take over the role. The registered nurses receives advice and input from the resident's general practitioner and family/whanau.
The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service.
Approved restraints include lap belts, bedside rails and hand holding.
Five resident files with restraint were reviewed. There is evidence that the five resident's care plans include reference to the restraint. Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome. Restraint monitoring forms are in place.
Five of five restraint files reviewed had a consent form detailing the reason for restraint and the restraint to be used. Monitoring forms are completed.
Bedrails are monitored two hourly, lap belts are monitored half hourly and hand holding is only used for the shortest periods of time during showering or toileting when the resident is resistant to cares being conducted. Dementia care staff interviewed (one enrolled nurse and two caregivers) were conversant with this procedure and its use and there are detailed instructions and pictures in the resident's file to guide staff in the safe use of hand holding.
The service has a restraint register that records sufficient information to provide an auditable record of restraint use.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

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

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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

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 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint coordinator or RN on duty reassesses each resident using restraint for their ongoing restraint needs.
The restraint coordinator monitors the review of safe restraint practice. A system of evaluation and review of the restraint for the resident takes place three monthly. This review assesses alternative strategies explored, desired outcome and whether it is being achieved, whether the restraint used is the least restrictive option, the duration of the restraint, the impact the restraint has on the resident, and were policies and procedures followed. Family/whanau participate in evaluations. Use of restraint is discussed at quality meetings, resident review meetings (last held on 12 February 2014) and at three monthly clinical reviews for each resident. Restraint use is also reviewed at the resident six monthly multi-disciplinary team meetings.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:
(a) Future options to avoid the use of restraint;
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
(d) Whether the desired outcome was achieved;
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education 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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator is responsible for ensuring restraint use is actively minimised, monitored and reviewed for each episode of restraint use. She is also responsible for the review of the restraint programme. This includes the review of restraint policies and procedures and review of the education programme for staff regarding the use of restraints and enablers (evidenced in an interview with the restraint coordinator and review of the internal restraint audit that takes place annually – April 2014). Episodes of restraint use, trends and progress made in minimising restraint are reviewed to ensure the restraint is only used when necessary, appropriate and safe.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The role of the infection control (IC) coordinator is held by one of the unit managers (RN) who has been in the post for eight months. The IC coordinator has IC qualifications and attends external microbiology updates. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. There is an IC committee including the IC coordinator, one other unit manager, the clinical manager, a household representative, kitchen representative, a caregiver representative and the HACCP coordinator. All members meet monthly. The IC coordinator reports to the general manager through the Quality and Risk committee in relation to IC matters. IC is an agenda item at two monthly quality meetings that looks at analysis, future prevention and how the IC programme is working. The service also subscribes to Bug Control. The programme is approved and reviewed annually by the IC coordinator and senior management team and external expertise when required. IC is a standing agenda item at the two monthly staff meetings and quality meetings (minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register.

There is a job description for the IC coordinator including the role and responsibilities of the position. Staff and residents are encouraged to have the flu vaccine.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The rest home/dementia rest home unit manager (RN) is the IC coordinator. There is an IC committee including the IC coordinator, one other unit manager, the clinical manager, a household representative, kitchen representative, a caregiver representative and the HACCP co-ordinator. All members meet monthly. The IC coordinator reports to the general manager through the clinical manager. The general manager reports to the board. IC matters are taken to all staff and quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. The IC coordinator has the main responsibility for reviewing the IC programme annually. The IC coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The IC coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

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

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

Attainment and Risk: FA

Evidence:

Windsorcare has infection control policies and an infection control manual which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC programme is reviewed annually by the IC coordinator who can access external specialist advice to do this. Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The IC coordinator is the unit manager (RN) who has undertaken specialist IC training. All new staff receive infection control education at orientation including hand washing and preventative measures. Infection control education occurs as part of the in-service training schedule. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.

The RN's or senior staff in each unit enter infections on to the infection register and the IC co-ordinator carries out a monthly analysis of the data. The analysis is reported to the monthly infection control meetings and significant issues reported up to the two monthly Quality and Risk meetings (minutes viewed). The facility subscribes to Bug Control. The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. IC is an agenda item at the two monthly quality and risk meetings that look at analysis, future prevention and how the IC programme is working. The IC coordinator reports to the general manager through the clinical manager. Any significant issues are reported weekly to the Board Chair and the full Board, monthly as appropriate.

Internal audit of infection control is included in the annual programme and occurs two monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and

methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. The role of the infection control (IC) coordinator is held by the unit manager (RN) who has been in the post for eight months. The IC coordinator has IC qualifications, and attends external microbiology updates. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The service reports that there have been no infection outbreaks.

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.)*