

Presbyterian Support Otago Incorporated - Ranui

Current Status: 21 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

Ranui Home and Hospital is one of seven aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of the Services for Older People, a division of the Presbyterian Support Otago. Ranui Home and Hospital is managed by a registered nurse who reports to the Director of Services for Older People, and is also supported by an Operations Support Manager, Quality Advisor and a Clinical Nurse Advisor. The service is certified to provide rest home, hospital and dementia level care for up to 48 residents.

There was full occupancy on the days of audit with nine rest home residents, 29 hospital residents and 10 dementia residents.

The organisation has an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service is commended for achieving two continuous improvements in the area of good practice and organisational management. This audit identified no areas for improvement.

Audit Summary as at 21 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
	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

Indicator	Description	Definition
	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 21 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.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational Management as at 21 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.		All standards applicable to this service fully attained with some standards exceeded.
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Continuum of Service Delivery as at 21 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.
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Safe and Appropriate Environment as at 21 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.
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Restraint Minimisation and Safe Practice as at 21 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.
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Infection Prevention and Control as at 21 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.
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Audit Results as at 21 July 2014

Consumer Rights

Ranui Home and Hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed.

Organisational Management

Ranui Home and Hospital is one of seven aged care facilities under Services for Older People - a division of Presbyterian Support Otago. The director and management group of Services for Older People provide governance and support to the manager. The manager is also supported by a clinical coordinator, registered nurses and care staff. The service is commended on their organisational management and support. There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly staff meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Lifestyle support plans are developed by the service's registered nurses who also have the responsibility for maintaining and reviewing the lifestyle support plans. Lifestyle support plans are holistic and goal oriented. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Risk assessment tools and monitoring forms are used to assess the level of risk and support required for residents. Lifestyle support plans are evaluated three monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The activity programme is varied and reflects the interests of the residents including community interactions. Medications are managed appropriately in line with accepted guidelines. 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 legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. The four weekly menu is designed and reviewed by a registered dietitian who is employed by the service. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur. Fridge/freezer temperatures and food temperatures are undertaken daily and documented. Kitchen staff have completed food safety training.

Safe and Appropriate Environment

The service has a current building certificate that expires on 30 May 2015. Preventative and reactive maintenance is carried out. Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. Hot water temperatures are monitored and recorded. There are staff on duty with a current first aid certificate.

Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are five restraints and four enablers in place. Any use of restraint or enablers is reviewed for each individual through the quality meeting and as part of the three monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers.

Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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:	Presbyterian Support Otago Incorporated
Certificate name:	Presbyterian Support Otago Incorporated - Ranui
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Ranui Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 21 July 2014 End date: 22 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:	48

Audit Team

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

Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed	7	Number of staff interviewed	14	Number of managers interviewed	4
Number of residents' records reviewed	7	Number of staff records reviewed	10	Total number of managers (headcount)	4
Number of medication records reviewed	14	Total number of staff (headcount)	75	Number of relatives interviewed	9
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	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 Wednesday, 13 August 2014

Executive Summary of Audit

General Overview

Ranui Home and Hospital is one of seven aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board (PSO). The service is part of the Services for Older People, a division of the Presbyterian Support Otago. Ranui Home and Hospital is managed by a registered nurse who reports to the Director of Services for Older People, and is also supported by an Operations Support Manager, Quality Advisor and a Clinical Nurse Advisor. The service is certified to provide rest home, hospital and dementia level care for up to 48 residents.

There was full occupancy on the days of audit with nine rest home, 29 hospital including two end of life care, and 10 dementia residents in the Gillespie dementia unit.

The organisation has an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identify that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service is commended for achieving two continuous improvements in the area of good practice and organisational management. This audit identified no areas for improvement.

Outcome 1.1: Consumer Rights

Ranui Home and Hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed.

Outcome 1.2: Organisational Management

Ranui Home and Hospital is one of seven aged care facilities under Services for Older People - a division of Presbyterian Support Otago. The director and management group of Services for Older People provide governance and support to the manager. The manager is also supported by a clinical coordinator, registered nurses and care staff. The service is commended on their organisational management and support. There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Key components of the quality management system link to

monthly quality committee meetings and monthly staff meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Outcome 1.3: Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Lifestyle support plans are developed by the service's registered nurses who also have the responsibility for maintaining and reviewing the lifestyle support plans. Lifestyle support plans are holistic and goal oriented. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Risk assessment tools and monitoring forms are used to assess the level of risk and support required for residents. Lifestyle support plans are evaluated three monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The activity programme is varied and reflects the interests of the residents including community interactions. Medications are managed appropriately in line with accepted guidelines. 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 legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. The four weekly menu is designed and reviewed by a registered dietitian who is employed by the service. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur. Fridge/freezer temperatures and food temperatures are undertaken daily and documented. Kitchen staff have completed food safety training.

Outcome 1.4: Safe and Appropriate Environment

The service has a current building certificate that expires on 30 May 2015. Preventative and reactive maintenance is carried out. Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. Hot water temperatures are monitored and recorded. There are staff on duty with a current first aid certificate.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are five restraints and four

enablers in place. Any use of restraint or enablers is reviewed for each individual through the quality meeting and as part of the three monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Outcome 3: Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	2	48	0	0	0	0	0
Criteria	2	99	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
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	CI	
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are regularly updated and reviews are conducted. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with an external benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. There is an internal audit schedule. The organisation has developed 16 continuous quality improvement groups with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each work stream is responsible for review of programmes and implementing and disseminating information. The clinical governance advisory group (CGAG) continues to monitor the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. Meetings are quarterly, and feedback is provided to PSO Board. CGAG reports and minutes are distributed and discussed at manager's forums meetings to ensure organisational learning opportunities are maximised. Quality initiatives at Ranui Home and Hospital implemented are resident focused and seek to improve outcomes for residents within the home environment and in the community. The relative survey conducted in April 2014 evidences that 100% of respondents agreed that the care and services received at Ranui Home and Hospital makes a positive difference in their resident's lives. The resident survey conducted in February 2013 also reflects these sentiments. Ranui Home and Hospital has been proactive in responding to benchmarking and quality activities with the following quality improvement activities currently in progress: improved communication for registered nurses since the clinical coordinator role have been introduced with a weekly newsletter and increased education; a standard of footwear brochure developed for staff and families to promote the use of correct footwear for falls prevention; review of the leadership team to increase the role of registered nurse leadership with the introduction of the clinical coordinator role; recycling in the kitchen and a hot wax therapy in use for residents requiring pain relief for arthritic hands.</p>
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are	CI	

Code	Name	Description	Attainment	Finding
		planned, coordinated, and appropriate to the needs of consumers.		
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	<p>Presbyterian Support Otago has a vision that they want to provide “a fair, just, and caring community for the people of Otago”. For the last nine years they have introduced and implemented a quality initiative organisational wide project called “Valuing the lives of Older People”. This has a major focus on the way they provide care, and staff are involved in this quality project (which includes specific training) and a focus to making a difference to the lives of people using their services is apparent.</p> <p>Ranui Home and Hospital has embraced this vision and it is evident in service delivery and feedback. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service is passionate about the project and should be commended for the continued on-going quality improvement focus around ‘what is important to the resident’. Valuing lives is incorporated into all aspects of service e.g. regular agenda item at quality meetings and is embedded in all staff training. The service has a mission statement and values listed to fulfil that vision. Valuing Lives action plan is regularly reviewed and communicated to all staff. The managers from all the PSO homes meet six weekly and there is a series of CQI work groups that focus on developing best practice in a number of specific areas. Within the Valuing Lives programme there are ‘non-negotiable’ standards which are communicated to staff at orientation and as part of the education programme. Care staff interviewed were knowledgeable regarding these standards which include language, valued roles, activities and use of time, appearance of people, and providing an ‘ordinary’ home like environment. A Valuing Lives newsletter is produced three monthly for staff and residents for all PSO facilities. PSO manager days include feedback from a number of areas including (but not limited to); conferences, aged care providers group, CQI reporting feedback from the different work streams, dementia, valuing lives, benchmarking, medication, infection control, moving & handling, workforce development, continence, documentation group. The clinical governance team has been strengthened over the past two years with the introduction of the clinical nurse advisor. There is a clinical governance advisory committee established that includes a PSO board member, a GP, Nurse Practitioner, independent quality/nurse advisors, director of aged care, and PSO clinical advisor and quality advisor. The group reviews benchmarking data, complaints, surveys, infection prevention and control, restraint use, audits, and any serious harm. The organisation has a formal benchmarking agreement with QPS Benchmarking Agency - Aged Care. Personnel from every Home participate in these groups, with each Manager either chairing or leading at least one group. The manager of Ranui Home and Hospital is the lead of the dementia CQI group and a member of the Valuing Lives group. The clinical coordinator is a member of the infection</p>

Code	Name	Description	Attainment	Finding
				prevention and control and benchmarking group. Two further RN's are part of the falls prevention and restraint minimisation groups respectively. The organisation has also commenced a six monthly senior nurse forum for sharing of information and discussion of benchmarking.

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:

The code of health and disability rights is incorporated into care. Discussions with three registered nurses (RN)s (one clinical coordinator, and two RN's) and five care workers (two from the dementia unit, and three from the rest home/hospital) identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with seven residents (five hospital and two rest home) and nine family members (two from the dementia unit, one from the rest home and six from the hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in October 2013.

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:

Code of rights leaflets are available in the front entrance foyer and throughout the facility. Code of rights posters are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in seven of seven files reviewed (two rest home, three hospital and two dementia).

D6, 2 and D16.1b.iii the information pack provided to residents on entry includes how to make a complaint, code of rights (COR) pamphlet, advocacy and HDC Commission.

D16.1bii. the families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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:

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for PSO Services for Older People, states "...will promote and enable older people to have positive roles that build on a person's strengths and abilities that are relevant to individual needs that support older people to be as healthy as possible, and that treat people with respect and dignity." There is a policy that covers elder abuse and neglect (ETH 010) and staff have completed training in November 2012. PSO Ranui Home and Hospital implements the organisation's Valuing Lives philosophy whereby people receiving services feel valued and respected.

D3.1b, d, f, i the service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4 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.

D4.1a Seven of seven residents (five hospital and two rest home) identified that cultural and /or spiritual values, individual preferences are identified. Seven residents interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times.

Two dementia resident files reviewed identified that cultural and /or spiritual values, 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:

There are current policies and procedures for the provision of culturally safe care for Māori residents including a Maori health plan, Tikanga best practice guidelines, cultural protocols, consultation with Maori and Pacific peoples services, bicultural commitment, principles in Te Reo, and spiritual, family and other support. Specialist advice is available and sought when necessary. Presbyterian Support Otago has a memorandum of understanding with Awai Te Uru Whare Hauora signed in July 2013. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness and Tangihanga training occurred in October 2013.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

D20.1i The service has developed links with local iwi. There are currently no Maori residents at Ranui Home and Hospital and Hospital.

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 cultural service response policy (BA 002) guides staff in the provision of culturally safe care. The philosophy of support for PSO Services for Older People, states "...will promote and enable older people to have positive roles that build on a person's strengths and abilities that are relevant to individual needs that support older people to be as healthy as possible, and that treat people with respect and dignity." This flows through into each person's care plan and could be described by five care workers (two from the dementia unit, three from the rest home/hospital) and three registered nurses (one clinical coordinator and two registered nurses) interviewed. During the admission process, the registered nurse or clinical coordinator, along with the resident and family/whanau, complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. Nine family members (one rest home, six hospital and two dementia) interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Weekly church services are provided to residents.

D3.1g The service provides a culturally appropriate service by implementing the PSO's mission statement.

D4.1c Seven of seven files reviewed (two rest home, three hospital and two dementia) included the residents social, spiritual, cultural and recreational needs. Seven residents interviewed (five hospital and two rest home) confirmed that the care provided meets their needs.

Two dementia 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 service has a discrimination, coercion, exploitation and harassment policy and procedures in place that include (but not limited to): code of rights, elder abuse and neglect, resident's financial/legal/personal affairs management, code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan. Interviews with five care workers (two from the dementia unit, and three from the rest home/hospital) confirmed an understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Interviews with staff reinforce professional boundaries. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with seven residents (five hospital and two rest home) identify that privacy is ensured. Discussions with the clinical coordinator and manager, and a review of complaints, identified no complaints of this nature.

Care workers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two care workers from the dementia unit could describe how they build a supportive relationship with each resident. Interviews with two families from the dementia unit confirmed the staff assist to relieve anxiety.

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: CI

Evidence:

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed by various continuous quality improvement work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with an external benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff.

There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food services, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control. The organisation has developed 16 continuous quality improvement groups with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each group is responsible for review of programmes and implementing and disseminating information. The organisation has well imbedded systems of communication, quality review and risk management.

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: CI

Evidence:

Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through a) resident participation including the complaints process, clinical reviews, resident meetings, implementation of the services philosophy; b) review of clinical effectiveness and risk management including benchmarking within PSO and externally around a range of key performance indicators, internal audits, CQI work streams, incident and accident reporting, development and review of policies and procedures that meet best practice and a health and safety programme; c) providing an effective workplace including recruitment processes, competency programme, annual appraisals, education and training programme, leadership development, and a multi-disciplinary team approach to care. All areas of service at Ranui Home and Hospital are discussed at six weekly Services for Older People's (SOP) management meetings where the manager reports to the director of SOP, participates in peer review, and is part of the wider organisations review implementation of policies and procedures. A clinical governance advisory group (CGAG) reports to the PSO board three monthly on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory group reviews all clinical indicators benchmarked.

Finding:

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are regularly updated and reviews are conducted. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with an external benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of

conduct expectations for staff. There is an internal audit schedule. The organisation has developed 16 continuous quality improvement groups with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each work stream is responsible for review of programmes and implementing and disseminating information. The clinical governance advisory group (CGAG) continues to monitor the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. Meetings are quarterly, and feedback is provided to PSO Board. CGAG reports and minutes are distributed and discussed at manager's forums meetings to ensure organisational learning opportunities are maximised. Quality initiatives at Ranui Home and Hospital implemented are resident focused and seek to improve outcomes for residents within the home environment and in the community. The relative survey conducted in April 2014 evidences that 100% of respondents agreed that the care and services received at Ranui Home and Hospital makes a positive difference in their resident's lives. The resident survey conducted in February 2013 also reflects these sentiments. Ranui Home and Hospital has been proactive in responding to benchmarking and quality activities with the following quality improvement activities currently in progress: improved communication for registered nurses since the clinical coordinator role have been introduced with a weekly newsletter and increased education; a standard of footwear brochure developed for staff and families to promote the use of correct footwear for falls prevention; review of the leadership team to increase the role of registered nurse leadership with the introduction of the clinical coordinator role; recycling in the kitchen and a hot wax therapy in use for residents requiring pain relief for arthritic hands.

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:

There is an open disclosure policy (ETH 011), a complaints policy and procedures, an incident reporting policy and adverse events policy.

Seven residents and nine family members stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur two monthly and the nurse manager and clinical coordinator have an open-door policy.

A review of nine incident forms for June 2014 from all the service levels indicate that family are notified of incidents when they choose this. There is a document in the front of each of the seven resident files sampled that is completed by family to detail when they wish to be contacted and what for. Nine family members (one rest home, six hospital and two dementia) report that they are contacted according to their wishes and also that the three monthly reviews are an excellent medium for providing information. Staff record in either progress notes or on a family communication form when family or next of kin are contacted.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

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

D16.4b the nine family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whānau have difficulty with written or spoken English that the interpreter services are made available.

D11.3 The information pack is available in large print and advised that this can be read to residents.

The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Gillespie unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident's handbook providing practical information for residents and their families.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.10: 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:

Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for seven files sampled. Seven files were reviewed and found to have valid consents. It was stated by the three registered nurses (one clinical coordinator and two registered nurses), that family involvement occurs with the consent of the resident. Other forms of written consent include consent to share information, consent for photographs and consent for names on doors/boards. A review of seven files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's file. Seven residents interviewed (five hospital and two rest home) confirm that they are given good information to be able to make informed choices. Five care workers (three rest home/hospital and two dementia), three registered nurses and the manager interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.

D13.1 there are seven of seven admission agreements sighted.

D3.1.d Discussion with nine family (six hospital, one rest home and two dementia) identified 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:

Client right to access advocacy services is identified for residents. Leaflets are available at the entrance of the service and throughout the facility. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided as part of Code of resident's rights training in October 2013.

D4.1d; Discussion with seven residents (two rest home and five hospital) and nine family members (one rest home, six hospital and two dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

D4.1e, The resident file includes information on residents' 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:

D3.1h Discussion with three registered nurses (one clinical coordinator, one hospital and one rest home/dementia unit), five care workers (two from the dementia unit, three from the rest home/hospital), seven residents (two rest home and five hospital) and nine family members (one rest home, six hospital and two dementia) identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.

D3.1.e Interview with the one diversional therapist (DT) described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, outings and church services. Entertainers are included in the home's activities programme. The DT and manager described how outings in a shared, community owned van is tailored to meet the interests of the residents.

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 in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation.

There have been no complaints received in 2013 and three complaints for 2014 as evidenced in the complaints/compliments folder. Response to complaints is recorded and includes meetings with complainants, performance management of staff if appropriate and recording of resolution and outcomes. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. There is a complaints register which is utilised for documenting complaints or concerns should they occur. Seven residents (two rest home and five hospital) and nine family members (one rest home, six hospital and two dementia) advised that they are aware of the complaints procedure and how to access forms. Complaints are discussed at staff meetings, and quality management meetings. The complaints procedure is provided to residents and families within the information pack at entry. It is also included in the dementia unit (Gillespie) specific information leaflet.

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: CI

Evidence:

Ranui Home and Hospital is one of seven aged care facilities under residential Services for Older People (SOP) - a division of Presbyterian Support Otago (PSO). The director and management group of Services for Older People provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full time operations support manager, a .8 FTE clinical nurse advisor and a .8 FTE Quality Advisor. The Operational Support Manager chairs six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Ranui Home and Hospital provides a monthly report to the Director of SOP on clinical, health and safety, service, staffing, occupancy, environment and financial matters. The manager is a registered nurse with experience in management and aged care and is also supported by an administration assistant, clinical coordinator, registered nurses and care workers. The manager has been in the role for 14 years. The home is certified to provide rest home, hospital and dementia care to up to 48 residents in a 10 bed dementia unit and a 38 bed rest home/hospital unit (all 38 are dual beds). There were 48 residents on the days of audit – nine rest home and 29 hospital, and 10 dementia residents in Gillespie unit. The organisation has a current strategic plan for 2012 - 2015, a business plan 2014 - 2015 and a current quality plan for 2014 - 2015. The organisational quality programme is managed by the manager, Quality Advisor and the director of SOP. The manager is responsible for the implementation of the quality programme at Ranui Home and Hospital. The service has an annual planner/schedule which includes audits, meetings, and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee at Ranui Home and Hospital includes the manager, clinical coordinator, and a group of registered nurses and care workers. The committee meets monthly to assess, monitor and evaluate quality care at Ranui Home and Hospital and Hospital. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. The manager has maintained at least eight hours annually of professional development activities related to managing the facility including attendance at regular managers' forums, attending a forum on staff management, a course on advanced care planning and attending in-house clinical related sessions.

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: CI

Evidence:

The director and management group of Services for Older People provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management.

Organisational staff positions also include a full time operations support manager, a 0.8 FTE clinical nurse advisor and a 0.8 FTE Quality Advisor. The Operational Support Manager chairs six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Ranui Home and Hospital provides a monthly report to the Director of SOP on clinical and financial matters. There is a clinical governance advisory group which meets three

monthly with terms of reference and standing agenda. There is a PSO organisational chart. The organisation has a current strategic plan for 2012 - 2015, a business plan 2014 - 2015 and a current quality plan for 2014 – 2015.

Finding:

Presbyterian Support Otago has a vision that they want to provide “a fair, just, and caring community for the people of Otago”. For the last nine years they have introduced and implemented a quality initiative organisational wide project called “Valuing the lives of Older People”. This has a major focus on the way they provide care, and staff are involved in this quality project (which includes specific training) and a focus to making a difference to the lives of people using their services is apparent.

Ranui Home and Hospital has embraced this vision and it is evident in service delivery and feedback. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service is passionate about the project and should be commended for the continued on-going quality improvement focus around ‘what is important to the resident’. Valuing lives is incorporated into all aspects of service e.g. regular agenda item at quality meetings and is embedded in all staff training. The service has a mission statement and values listed to fulfil that vision. Valuing Lives action plan is regularly reviewed and communicated to all staff. The managers from all the PSO homes meet six weekly and there is a series of CQI work groups that focus on developing best practice in a number of specific areas. Within the Valuing Lives programme there are ‘non-negotiable’ standards which are communicated to staff at orientation and as part of the education programme. Care staff interviewed were knowledgeable regarding these standards which include language, valued roles, activities and use of time, appearance of people, and providing an ‘ordinary’ home like environment. A Valuing Lives newsletter is produced three monthly for staff and residents for all PSO facilities. PSO manager days include feedback from a number of areas including (but not limited to); conferences, aged care providers group, CQI reporting feedback from the different work streams, dementia, valuing lives, benchmarking, medication, infection control, moving & handling, workforce development, continence, documentation group. The clinical governance team has been strengthened over the past two years with the introduction of the clinical nurse advisor. There is a clinical governance advisory committee established that includes a PSO board member, a GP, Nurse Practitioner, independent quality/nurse advisors, director of aged care, and PSO clinical advisor and quality advisor. The group reviews benchmarking data, complaints, surveys, infection prevention and control, restraint use, audits, and any serious harm. The organisation has a formal benchmarking agreement with QPS Benchmarking Agency - Aged Care. Personnel from every Home participate in these groups, with each Manager either chairing or leading at least one group. The manager of Ranui Home and Hospital is the lead of the dementia CQI group and a member of the Valuing Lives group. The clinical coordinator is a member of the infection prevention and control and benchmarking group. Two further RN’s are part of the falls prevention and restraint minimisation groups respectively. The organisation has also commenced a six monthly senior nurse forum for sharing of information and discussion of benchmarking.

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:

During a temporary absence of the manager, Ranui Home and Hospital is managed by the clinical coordinator, with support from the operations support manager and the clinical nurse advisor. The clinical coordinator has worked in aged care for the past four months and is an experienced clinician. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home and hospital level care.

A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which 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:

There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO. The business plan for 2014-2015 outlines the financial position for PSO with specific goals for the coming year. Goals and objectives relate to building strong and connected communities, provide leadership within the sector, and maximise resource to deliver on the PSO mission.

The quality plan for 2013-2014 includes the quality framework, model and processes, benchmarking, meetings, monitoring and reporting, internal and external audits, food safety, valuing lives programme, policies and procedures, gaining feedback from residents and families, and ensuring a safe environment. A Quality Advisor is employed to oversee and manage the quality programme for all PSO homes (.8 FTE). The Quality Advisor develops a quarterly report which presents progress with the current quality plan including external audits, policies and procedures, CQI work groups, infection prevention and control, restraint, feedback, internal audits and a summary of findings from each audit and each facility, benchmarking, and valuing lives. The 16 continuous quality improvement work streams include: infection prevention and control, documentation, continence, restraint, dementia, pressure area/wound care, moving and handling, falls, medications, Liverpool care pathway, policies and procedures, benchmarking, financial, competencies, workforce development, and valuing lives. Six of these groups are in abeyance for 2014 – Liverpool care pathway, policy and procedure, financial resources, medications, pressure area/wound care and continence. Discussion around these areas of service are included in other work groups or at manager's forums. Each group is led by a designated manager/leader. The role of each group is to address the needs identified within each specialised work stream. Projects and issues are identified by the managers group (six weekly meeting) and allocated to the appropriate work stream for research, review and action planning.

The quality improvement initiatives for Ranui Home and Hospital have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently a number of documented quality improvement initiatives being implemented and relate to review and analysis of staffing and clinical leadership with the introduction of the clinical coordinator role in March 2014, and increasing registered nurse cover for rest home and dementia residents, development of a dementia unit relatives newsletter to keep families up to date with what is happening in the unit and advise them of staff movements, modifying the rest home dining room tables to enable a more home like environment for meal times, improving communication between registered nurses with a weekly newsletter now provided by the clinical coordinator, producing a standard of footwear brochure for residents, families and staff on the safe selection of appropriate footwear for falls prevention, recycling waste in the kitchen, and use of hot wax therapy as pain relief for residents with painful arthritic hands. Each QI has been reviewed for effectiveness of implemented actions and current progress. Ranui Home and Hospital is part of the PSO internal benchmarking programme with feedback provided three monthly around indicators provided to the Quality Advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned. The clinical advisory group also receives reports for all PSO homes and provides oversight and follow up on areas for improvement. The clinical nurse advisor provides a monthly newsletter which is available for all care staff to read. The contents include specific topics relating to: medication management (July 2014), infection prevention and control (June 2014), care planning (May 2014), restraint (April 2014).

Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. There are designated health and safety staff representatives. The health and safety committee meets monthly.

Progress with the quality assurance and risk management programme is monitored through the six weekly managers meetings, monthly Ranui Home and Hospital quality committee meetings, monthly health and safety/infection control meetings, monthly registered nurse meetings, and six weekly staff meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, wounds, complaints, and health and safety. The monthly quality committee meeting agenda includes (but is not limited to): previous meetings minutes, food service, infection surveillance, complaints, laundry service, health and safety, occupancy, restraint, audits, surveys, benchmarking reports, activities, nursing/clinical, and review of action plans. Minutes are maintained (sighted for 9 July 2014)

and staff are expected to read the minutes and sign off when read (confirmed by five care workers at interview). Registered nurse meeting agenda covers clinical issues, medication errors, education sessions and general business. Staff meetings are held six weekly with agenda items including a report from the quality committee, internal audits, survey results, nursing and caring, incidents and accidents, quality improvements, staffing and shifts and valuing lives programme (minutes sighted for 16 July 2014). Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings take place two - three monthly in each unit with laundry, activities, survey outcomes and feedback, and food/meals as regular agenda items. Minutes sighted for each unit for most recent meeting in 2014. A weekly staff newsletter is written to inform staff of upcoming meetings, education sessions, policy updates, and general information and reminders.

There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food servicers, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control. Advised by the Quality Advisor that all areas of non-compliance identified at audits are actioned for improvement.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. The director of SOP, the clinical nurse advisor and the Quality Advisor are responsible for development and review of policies and procedures along with each associated CQI group.

Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. There are procedures to guide staff in managing clinical and non-clinical emergencies. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care workers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by a registered nurse and/or the clinical coordinator who completes any additional follow up. The manager and Quality Advisor collates and analyses data to identify trends. Results are discussed with staff through the monthly health and safety meetings, monthly quality meetings, six weekly staff meetings, six weekly management meetings, and provided to PSO internal benchmarking. Internal Audits for 2013/2014 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey (2013) and a family survey (2014) is conducted biennially. The surveys evidences that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, monthly health and safety/infection control meetings, and six weekly staff meetings including actions to minimise recurrence. Falls, medication errors and skin tears are reported and benchmarked through the PSO internal benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and nine family members interviewed (one rest home, six hospital, two dementia) stated they are informed of changes in health status and incidents/accidents. The type of incidents reported on include falls, skin tears, medication errors, near misses, choking, and challenging behaviours. A sample of nine incident reports for June 2014 were reviewed with a selection from each service level and related to falls (six), skin tears (two), near miss (1), and choking (1). The reports related to one rest home resident, two hospital residents and two dementia residents. All reports and corresponding resident files reviewed evidence that the service conducts an immediate assessment and clinical response for the resident following an injury including referral to emergency services if required, review of risk assessments, updating of long term care plans or commencement of short term care plans were required. Neurological observations are undertaken for any resident who has sustained an unwitnessed fall. A frequent falls review is also conducted for residents who have had three or more falls in a month. There is evidence that the GP has been informed of falls and injuries and this is recorded in medical notes and at three monthly multidisciplinary team meetings. Wound assessments and care plans are developed for skin tears and pressure injuries. Reports were completed and family notified as appropriate. There is a family communication sheet in every resident file where staff record contact and communication with family members – confirmed at nine relative interviews. An incident/infection summary is maintained for each individual resident. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Medication errors are also reported. A monthly summary of accidents and incidents is compiled by each clinical coordinator with subsequent analysis and investigations.

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:

The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, general practitioners, physiotherapist, dietitian, podiatrist, and occupational therapist is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. There are 75 staff employed at Ranui Home and Hospital in full time, part time and casual positions. Ten staff files were reviewed (the manager, clinical coordinator, two registered nurses, one care worker from the dementia unit, three care workers from the rest home/hospital unit, one diversional therapist and one cook). The manager advised that staff turnover has been higher of late due to staff moving out of the area, however, some core staff have worked at Ranui Home and Hospital for over 10 years. Advised that reference checks are completed before employment is offered as evidenced in two recently employed staff files reviewed (one care worker and one clinical coordinator). The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Orientation is tailored to both service levels. Three registered nurses and five care workers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in 10 of 10 staff files reviewed. Annual appraisals are conducted for all staff as evidenced in nine of ten files reviewed (clinical coordinator commenced employment in the past six months).

Discussion with the manager, clinical coordinator, registered nurses and care workers confirm that a comprehensive in-service training programme is in place. All relevant aspects of care and support have been provided. There is an in-service calendar for 2014. A registered nurse is the career force trainer and assessor and facilitates the in-service education programme with the clinical coordinator and manager. The annual training programme exceeds eight hours annually. Care workers have completed either the national certificate in care of the elderly or have completed or commenced the Career force aged care education programme. The manager and registered nurses attend

external training including conferences, seminars and sessions provided by PSO and the local DHB. The manager has attended education and training sessions from external providers in 2013 and 2014. There are eight care workers who work in the dementia unit – seven have completed the limited credit programme for career force which includes dementia unit standards. One new staff member is in the process of completing these unit standards. The education coordinator maintains education records and attendance rates. A three hour orientation session is held by the education coordinator for new staff (last conducted May 2014) and covers health and safety, infection control, fire safety and evacuation procedures. Compulsory education is provided around fire and evacuation, restraint, back care and manual handling, and infection control.

Education provided so far in 2014 includes: challenging behaviours, fire safety and evacuation, continence, documentation and policy roll out, health and safety, restraint and de-escalation, back care and safe manual handling, palliative care and syringe driver training.

Education for 2013 included preceptorship training, cultural safety, code of consumer rights and advocacy, medications, emergency preparedness, challenging behaviours, back care, first aid, infection control and chemical safety.

Fire evacuation drill last conducted on 18 June 2014.

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 staffing levels guide and human resource policies includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements for the rest home, hospital and dementia residents. There is a minimum of one care worker on duty in the 10 bed dementia unit as well as an RN who is employed for 25 hours per week for the rest home and dementia residents. The rest home/hospital unit has a minimum of one registered nurse and one care worker on duty. There is a clinical coordinator employed for .8 FTE. There is a registered nurse on duty 24/7 in the rest home/hospital unit. The manager works 40 hours per week and the administration assistant works 15 hours per week. There are two care workers in the dementia unit on morning and afternoon shifts. The rest home/hospital unit has a mixture of long and short shifts for morning and afternoons. Activities staff include one diversional therapist and two activities coordinators. Cleaning staff work every day. Kitchen staff include a cook, a tea cook and a kitchen assistants. A maintenance person is contracted to PSO Ranui and visits at least daily to attend to maintenance issues. A laundry person is employed every day. Interviews with three registered nurses, five care workers, seven residents and nine family members identify that staffing is adequate to meet the needs of residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. Residents' files are protected from unauthorised access by being locked away in locked cupboards within the locked nurse's station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

D7.1 entries are legible, dated and signed by the relevant care workers or RN including designation

Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

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:

Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the H&D Code of Rights, advocacy and complaints procedure.

D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract.

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

E3.1 Two resident files were reviewed from the dementia unit and all include a needs assessment as requiring specialist dementia care

E4.1.b There is written information on the service philosophy and practices particular to the 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:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

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 reason for declining service entry to residents to the service is recorded on the declined entry form, and should this occur the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. The manager reports that there has been no reason to decline a potential resident from the service. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.

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; D16.3i; 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:

The service completes an initial assessment on the day of admission and completes an initial care plan within 48 hours.

Lifestyle support plans are developed by registered nurses who also have the responsibility for maintaining and reviewing care plans. Lifestyle support plans are developed in consultation with residents and family/whanau where appropriate. Seven residents (five hospital and two rest home) and nine family members (one rest home, six hospital and two dementia) confirmed their involvement in the care planning process.

Assessments in seven resident files sampled were completed by relevant multidisciplinary staff; i.e.: a) physiotherapy assessment - physiotherapist, b) falls risk assessment, continence assessment, pain assessment and pressure areas risk assessment - registered nurses, c) nutritional assessment/status - dietitian, d) medical assessment – GP, e) activities assessment –diversional therapist and f) functional performance -occupational therapist.

The resident mobility transfer plan is included in the three monthly review with notes by the physiotherapist and exercise therapist. The service employs a physiotherapist for 8 hours per week and a physiotherapist assistant (exercise therapist) 12 hours a week. The dietitian visits every two months or as required and sees every new resident, completing a nutritional assessment. The occupational therapist is employed for four hours per week and sees every new resident to complete a functional assessment.

D16.2, 3, and 4: the seven files reviewed for three hospital, two rest home and two dementia residents included:

The seven files reviewed identified an assessment was completed within 24 hours and the long term residents files the lifestyle support plan was completed within three weeks. There is documented evidence that the lifestyle support plans are reviewed by a registered nurse and amended when current health changes. Five lifestyle support plans evidenced evaluations completed at least three monthly. Two residents (one rest home and one hospital) have been at the service less than three months.

D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in all resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. Documentation of GP visits were evident that reviews were occurring in the time frames documented.

A range of assessment tools were completed in resident files on admission and completed at least three monthly including (but not limited to); a) physiotherapy assessment -completed by the physiotherapist, b) falls risk assessment, continence assessment, pain assessment and pressure areas risk assessment -completed by the registered nurses, c) nutritional assessment/status completed by the dietitian, d) medical assessment - completed by the GP, e) activities assessment completed by the diversional therapist and f) functional assessment completed by the occupational therapist.

Care workers complete lifestyle notes at the end of each shift. There is an appropriate hand-over briefing between shifts that staff are able to fully describe.

The GP interviewed stated he is confident with the service and states that staff contact him with appropriate information (including observations) in regards to resident concerns and altered health status.

Tracer Methodology Hospital;

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

Tracer Methodology Rest Home;

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

Tracer Methodology Dementia;

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.4: 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:

All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks as evidenced in seven of seven files reviewed (two rest home, three hospital and two dementia). Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments are completed on admission and at least three monthly as part of the three monthly review and include the following; a) physiotherapy assessment -completed by the physiotherapist, b) falls risk assessment, continence assessment, pain assessment and pressure areas risk assessment -completed by the registered nurses, c) nutritional assessment/status completed by the dietitian, d) medical assessment - completed by the GP, e) activities assessment –completed by the diversional therapist and f) functional assessment - completed by the occupational therapist. Pain assessments were evidenced as completed with on-going monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan. The service is gradually changing to the use of InterRAI assessments. Two registered nurses have completed InterRAI training and the service is starting the process of using InterRAI assessments for residents. Seven residents (five hospital and two rest home) and nine family members (one rest home, six hospital and two dementia) interviewed are very satisfied with the support provided.

E4, 2a Challenging behaviours assessments are completed.

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:

Resident files include (but not limited to); a) information page, b) admission checklist, c) informed consent, d) resuscitation, e) information in the event of death, f) lifestyle support plan, g) incident and accident form, h) residents outings, i) lifestyle notes, j) observation chart, k) clinical notes, l) medical assessment, m) lab forms, n) initial resident assessment, o) social history and lifestyle, p) physiotherapy assessment, q) correspondence, r) transfer forms, and s) care needs level.

Lifestyle support plan identify, needs, goals, and intervention. Lifestyle support plan includes, a) social roles, b) culture/spirituality/religion, c) communication, d) mobility, e) nutritional status, f) personal cares, g) skin integrity, h) elimination, i) rest & sleep, j) pain management, j) issues of consent, k) medication risk, l) challenging behaviour, m) psychotropic medication, n) roles/support needs and o) acute health needs. Lifestyle support plans are comprehensive and provide interventions for individual holistic care.

The following policies are in place to support service delivery planning: a) continence management including catheters, bowel and bladder policies and procedures, b) disturbed behaviour policy, c) pain management policy, d) personal hygiene and grooming policies and procedures including standards for the nursing and care of the older person, e) pressure care and skin care policies and procedures, and f) wound management policies and procedures.

D16.3k: The service has a specific acute health needs care plan that includes short term cares. There is evidence of these being used for urinary infections, respiratory infections, nutritional/dietary needs and wound care as part of the service delivery.

D16.3f: seven resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident.

Resident's files are integrated and include (but not limited to) input from GP, physiotherapist, dietitian, occupational therapist, diversional therapist, and nursing/caring

E4.3 two resident files reviewed from the dementia unit identified current abilities, level of independence and specific behavioural management strategies.

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:

The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management.

A resident survey conducted in March 2013 and a relatives survey conducted in April 2014, evidence that respondents were overall very satisfied with the care provided by the service.

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

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-service has been provided in June 2014 and wound management in-service has been provided in September 2012 and planned for 2014. Registered nurses interviewed were able to describe access to specialist services if required.

Wound assessment and wound management plans are in place for three residents with five wounds (one rest home, two hospital). One rest home resident has a leg ulcer and a leg skin tear. One hospital resident has a leg skin tear and a leg bruise and another hospital resident has a hand skin tear. All wounds have documented assessments, treatment plan and evaluations in place as sighted with input from the GP. All wounds show evidence of healing. There are no documented pressure areas.

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 is one diversional therapist and two activities coordinators at the service who are responsible for the planning and delivery of the activities programme. One of the diversional therapists has been employed at the service for over 23 years and has been in the activities role for 20 years (has just qualified as a diversional therapist). The diversional therapist attends diversional therapy workshops three times a year. Activity staff are employed to work Monday-Friday and there is a roster for one of the activity staff to work on Saturdays. The diversional therapist works mainly in the dementia unit and activities coordinators facilitate activities in the hospital/rest home area to give variety to the programme. The activity staff meet monthly to plan and review the activity programme which is also reviewed by the manager. The occupational therapist also attends the meeting to ensure the programme is suitable to meet the needs of the residents. There is a separate programme for the dementia unit, rest home and hospital. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. The weekly activity programme is displayed on the notice boards and each resident has a copy of the programme in their rooms. Residents from the rest home and hospital can choose which activity they wish to attend from the rest home and hospital programme. On the day of audit residents were observed being actively involved with a variety of activities newspaper reading and musical entertainment. The residents from the dementia unit were observed being involved with baking. The programme is developed weekly. 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 (a 'this is my life' form completed to be used as an initial activities support plan).

The programme includes residents being involved within the community with social clubs, churches and schools and kindergarten. On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan and this is reviewed three monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide

range of activities offered that reflect the resident needs including but not limited to: morning tea outings, sing-alongs, music appreciation, crafts, word games, exercises, floor games, bowls, exercises and tai chi. Participation in all activities is voluntary.

The service uses the community van for transportation which is owned by the area community group. The service also has a car which is used for transportation. Residents interviewed described visiting other facilities, going out for lunches, shopping and going to Probus club. The diversional therapist and activities coordinators have a current first aid certificate. There are four volunteers that assist with a variety of activities including helping with morning tea.

Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held two- three monthly and the diversional therapist facilitates the meeting. Feedback on the activities programme is encouraged at the meetings. The last relative's annual satisfaction survey in April 2014 reported overall satisfaction with the activities programme.

D16.5d: Resident files reviewed identified that the individual activity plan is reviewed at care plan review.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents and families are invited to an admission review meeting at three - six weeks post admission. Families appreciate the opportunity to review the care needs of their family member. Three monthly multi-disciplinary team meetings includes; allied health staff, resident and family (if requested) which cover; physiotherapy needs, skin integrity, medication/pain management, social interaction, family concerns, risk management.

A range of assessment tools are completed and reviewed at least three monthly including (but not limited to); a) physiotherapy assessment - b) falls risk assessment, continence assessment, pain assessment and pressure areas risk assessment c) nutritional assessment/status and d) medical assessment. Short term care plans are in place for infections, skin tears, and pain and health changes.

Documentation of GP visits were evident that reviews were occurring in the time frames documented.

D16.4a: Lifestyle support plans are evaluated three monthly or more frequently when clinically indicated.

D16.3c: All initial care plans were evaluated by the registered nurse within three weeks of admission.

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

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

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 service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. In managing the referral process the service provides: a) appropriate transfer of relevant information and b) follow-up occurs where appropriate.

The service has a referral form, discharge procedure, which includes managing acute emergency /ambulance and hospital transfers.

D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care.

D 20.1: Three registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse, speech language therapist, neurologist (for Parkinson's) and dietitian.

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:

The service has transfer /discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation e.g. GP letter, medication charts, care plans are copied and forwarded with the resident.

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 follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care.

The service has four weekly medico blister packs. Blister pack medications are checked on arrival at each unit by a registered nurse. There is a signed agreement with the providing pharmacy. There is one main treatment room that services the hospital/rest home and the dementia unit. There are two medication trollies and medication folders in the rest home/hospital area and one medication folder in the dementia unit (there is no trolley). Medications are kept in a locked cupboard in a locked office in the dementia

unit and administered individually to residents. One medication trolley is kept in a locked treatment room and one trolley is kept in a locked cupboard. Medications requiring refrigeration are kept in a separate fridge in the main treatment room. The fridge is monitored daily, with documented evidence of this being available.

Fourteen individual resident's medication charts were sighted. Resident medication charts are identified with photographs and allergies are recorded. Individual resident standing order medications have been approved by the GP's and reviewed three monthly. The GP's have documented on all medication charts indications for use of PRN medication.

Registered nurses administer medications in the hospital and senior care workers administer medications in the rest home and dementia units.

Three staff members were observed during medication rounds (one registered nurse and one senior care worker in the in the hospital/rest home and one senior care worker in the dementia unit). All three staff followed correct administration procedure, checking the blister pack with the GP prescription chart and signing for the medication after the resident had taken the medication. Staff comply with the service medicine management policies procedures and there is evidence of on-going education and training of staff in relation to medicine management (October 2013 and October 2012). The service retains specimen signatures of those staff that have been assessed as being competent to administer medications.

There is one locked safe in the main treatment room and one controlled drug register for the safe keeping and administration of controlled drugs. Weekly stock takes are undertaken as sighted.

Allergies are identified on front of medication administration charts with a large bright warning sticker. The service has systems to ensure: a) residents medicine allergies/sensitivities are known and recorded, b) adverse reactions and administration errors are identified and recorded. Care of the resident following medication error policy and procedure. The service has bright stickers used in the progress notes to document prn medications used. The service has three monthly reviews of psychotropic medications.

The self-medicating policy includes procedures on the safe administration of medicines. There is currently one rest home resident who self-medicates one medication only. Self-medicating competency is included on three monthly clinical review form. The medication is checked weekly and secured in a locked drawer in the resident's room.

Weekly physical stock take of controlled drugs is completed and equipment such as oxygen is routinely checked. There are six eye drops (hospital) in use and all sighted with dates of opening. .

D16.5.e.i.2; All 14 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food services manual includes (but not limited to); a) safe storage, b) late meals, c) temperature testing of chiller/freezer, d) disposal of kitchen waste, e) health standards for kitchen staff, f) protective clothing, g) chemical storage, h) staff meals, i) receiving supplies, j) access to kitchen, k) Menu planning, l) special diets, m) nutritional content, n) food preparation, presentation, costings, o) tray setting, p) temperature of food, q) HACCP and r) Kitchen safety.

The service has a food service manager who works full time. The food service manager is a cook with many years of experience and is responsible for menu planning (alongside the dietitian), training of staff and all cleaning and audits. One other qualified chef is employed. Four weekly summer and winter menus are in place that have been reviewed by the dietitian. Food Service managers from all PSO homes meet annually. All staff working in the kitchen have food safety qualifications.

Fridge and freezer temperatures are monitored daily. Food temperatures are recorded and also food on delivery to the service is recorded. Dishwasher temperatures are also recorded. HACCP audit of the food safety programme last occurred in July 2014.

A registered dietitian is employed by Presbyterian Support Otago (PSO) and attends Ranui Home and Hospital every two months and as required. She has input into the provision of special menus and diets where required and completes a full dietary assessment on all residents at the time they are admitted. Residents with weight loss are reviewed by the dietitian every one to two months. Residents with special dietary needs have these needs identified their care plans and these needs reviewed periodically as part of the care planning review process. Residents are referred to the dietitian if they have had a 10% change in body weight.

A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Discussions with nine family members (one rest home, six hospital and two dementia) confirmed that at three month clinical reviews diet and other nutritional needs were discussed.

Residents' food preferences are identified at admission. Resident meetings discuss food as part of their meetings. Residents stated they had some choice in meals offered.

Nine of nine relatives stated that the food provided was good and that their family member always received an alternative if there was something on the menu they didn't like. The last relative's survey in April 2014 reported overall satisfaction with food services. Discussions with seven residents (five hospital and two rest home) stated the food was excellent.

Special equipment is available such as lipped plates/assist cups/grip and built up spoons. The service employs an occupational therapist (OT) who would access any other special equipment. Internal audits are undertaken through the HACCP programme and the food service manager was able to describe the audit processes undertaken. Food services audits are conducted in October each year.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: 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:

The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. General waste is collected twice a week from Ranui Home and Hospital and hazardous waste is stored in locked yellow bins in the waste storage area until collected on a fortnightly basis.

Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety data sheets were available in the laundry and sluice areas. Chemicals are secured in sluice room cupboards and the laundry chemical storage room.

Gloves, aprons and goggles are available for staff.

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 30 May 2015. The maintenance person is contracted to the service as required. The maintenance register is checked daily and urgent issues are addressed immediately or external contractors are arranged. The maintenance person is available on call after hours. There is a preventative building maintenance programme which ensures that all legislation is complied with. The environment and buildings are well maintained. Electrical equipment was last tested in November 2013. Hoists are due for service in August 2014. Medical equipment was calibrated on 11 November 2013. The facility's car has a current warrant of fitness which expires February 2015.

Corridors are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails appear appropriately located. There is a maintenance work notification book for staff to communicate with maintenance staff issues and areas that require attention.

There are many small and moderate sized outside courtyard areas with seating, tables and umbrellas available. Pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids electrical beds.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c: There is a safe and secure outside area that is easy to access

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

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:

In the dementia unit there are 10 rooms. There are three communal showers and three communal toilets. The hospital/rest home care units all share an en-suite with toilet facilities between two rooms. There are resident's communal toilets around the facility near to lounges and dining rooms and staff toilets and visitor's toilets around the facility.

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:

Residents rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in resident's bed and equipment can be transferred between rooms. Mobility aids can be managed in shared en-suites. Residents and relatives confirm satisfaction with their rooms.

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:

The service has a large lounge and dining area in the hospital/rest home and dementia unit and another smaller seating lounge area in the hospital/rest home unit. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas and courtyards and this was confirmed by staff interviewed.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. Seating and space is arranged to allow both individual and group activities to occur.

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:

The facility has a laundry that services the facility. There is a dirty to clean flow that staff could describe. Laundry staff are responsible for personal laundry as well as bed and bathroom linen.

The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety data sheets are displayed in the laundry and also available in the chemical storage areas.

Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Laundry staff have completed chemical safety training (June 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:

There is at least one staff member is on duty at all times with a first aid certificate. All registered nurses have current first aid certificates and care staff are encouraged to maintain a current first aid certificate. The original fire evacuation scheme was approved by the NZFS on 31 January 1997 and updated on the 2 June 2003. Emergency preparedness plan and disaster recovery manual includes civil defence, emergency such as fire, evacuation, cardiac arrest, bomb threat, missing residents, loss of staff cover and also includes critical supplies and equipment list, evacuation methods, and a pandemic plan

The service has implemented policies and procedures for civil defence and other emergencies. There are staff on duty with a current first aid certificate.

The service has in place a civil defence policy and emergency contacts list. The policy details risks in relation to: (a) fire and evacuation process, (b) earthquake, (c) flooding (d) storm, (e) bomb threat, and (f) power loss.

A fire evacuation drill was last conducted in June 2014.

The emergency lighting policy states that there are battery-operated emergency lighting available and staff interviewed confirmed this is functional. Extra blankets, torches and supplies are available. There is sufficient food in the pantry to last for three days in an emergency and there is sufficient emergency supplies of stored water.

Call bells were adequately situated in all communal areas, toilets, bathrooms and personal bedrooms. Care workers wear pagers to alert them to residents who have activated call bells for assistance. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews.

The service has a visitor's book at reception for all visitors including contractors to sign in and out. Access by public is limited to main entrance. Door checks are made by staff on afternoon and night shifts. There is a security firm contracted to make twice nightly checks of external doors and grounds.

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:

General living areas and resident rooms are appropriately heated and ventilated. Living areas and bedrooms in the hospital/rest home units and dementia unit are controlled centrally to allow areas to be suitable heated. Room temperatures can be individually adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.

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:

The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the three registered nurses (one clinical coordinator and two registered nurses) and five care workers (two from the dementia unit and three from the rest home/hospital).

There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures.

The process of assessment and evaluation of enabler use is in place. Currently there are three hospital residents with restraint (two residents with lap belt and bed rails and one with bedrails) and four enablers (bedrails) in place. There is a monthly register for restraint and enablers.

There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

Restraint minimisation procedures include: the approval process, assessment, recording/documenting use (consent), reducing the risks, evaluation, monitoring and quality review of use.

Types of restraint/enablers include bedrails and lap belts. A restraint register is completed and includes: name of resident, type of restraint, enabler or restraint, consent, review date. Restraint is reviewed three monthly at clinical review for individuals and in each area.

A restraint approval group is part of the nursing/caring monthly meeting and reviews all restraint and enabler use. All PSO sites send statistics and issues monthly to the organisations restraint co-ordinator. Issues are discussed by phone/email, and the sites meet quarterly.

Individual care plans document restraint/enabler use. Resident files reviewed with restraint and enablers were as follows: two hospital restraints and two hospital enablers. All restraint/enabler plans were completed appropriately with corresponding forms for assessment, consent, monitoring and review. Staff are trained in safe restraint/enabler use and challenging behaviour. In-service for challenging behaviour held in September 2013 and in service for restraint minimisation held in March 2014. Discussions with five care workers and three registered nurses identified their knowledge in relation to restraint/enabler use and management techniques. Managing challenging behaviour training is included in the unit standards for all carers working in the dementia unit and covers dementia, managing challenging behaviours, triggers and de-escalation.

E4.4a: The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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:

The restraint coordinator is the registered nurse from the hospital who is experienced in aged care. She has been employed at the service for nine years and has been the restrain coordinator for four years. Assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner.

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:

The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In two files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family/whanau involvement and a specific consent for enabler / restraint form is used to document approval. These were sighted in the two restraint files reviewed.

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 restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The two files reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two files reviewed. Two files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. Assessments are completed. A three monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is up dated each month.

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.

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

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.

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

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 service has documented evaluation of restraint every month. In the two restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.

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 service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings.

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:

PSO Ranui Home and Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The clinical coordinator is the designated infection control nurse with support from the clinical nurse advisor. The infection control programme is linked into the incident reporting system. There is a health and safety/ infection control meeting and includes discussion and reporting of

infection control matters. The infection control programme was reviewed in June 2014. The infection control nurse is also on the infection prevention and control CQI work group for PSO. Minutes of meetings are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.

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.

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

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.

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

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:

A registered nurse (clinical coordinator) at Ranui Home and Hospital is the designated infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice and has completed an on-line infection control update (completed in July 2014). The IC nurse and IC team (comprising designated staff from each area) has good external support from the local laboratory infection control team, Public Health South, clinical nurse advisor and infection control expert from the Southern DHB and local hospital. These avenues of support were accessed during and after a recent Norovirus outbreak (December 2013). The infection control team is representative of the facility. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.

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:

There are infection control policy and procedures for PSO Ranui Home and Hospital appropriate to the size and complexity of the service. Infection control is one of 16 CQI groups within PSO.

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by the organisation and reviewed and updated annually. Last review conducted May 2014. Ranui Home and Hospital infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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 infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from the clinical nurse advisor and external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. Infection control training was provided in July 2012 (hand hygiene), and as part of a hand hygiene audit conducted with staff in May 2014. Education is also provided in the form of posters and information boards developed by the infection control nurse and placed in the staff room. The focus of each poster includes topics such as hand hygiene, and use of personal protective equipment. The IC nurse has completed infection prevention training in July 2014. Advised by the IC nurse and clinical advisor that the facility had a Norovirus outbreak in December 2013 which affected a small number of residents (six in the rest home/hospital area and none in the dementia unit). Visitors were advised of the outbreak and are advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that was appropriate to their needs and this is documented in medical records.

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 surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection, treatment, follow up, review and resolution. Individual short term care plans are available for each type of infection. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality/head of department meetings, monthly nursing and caring/infection control meetings and three monthly staff meetings. Infection rates are benchmarked internally and externally. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager and to organisational management. The recent Norovirus outbreak was reported to organisational management and to Public Health South. The outbreak lasted approximately two weeks and affected 74 residents. The service responded by isolating residents and locking down the facility till the infection cleared. The service has held a debrief meeting (23 June 2014) to evaluate the outbreak and service response with an action planned developed around identified areas for improvement for the future.

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.)*