# Sylvia Park Rest Home Limited

## Current Status: 10 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Sylvia Park rest home and hospital provides care for up to 81 residents at rest home and hospital level of care. Occupancy on the day of audit was 76. There were 44 hospital residents, and 32 rest home residents. The owner/facility manager has been operating the facility since 1996 and is supported by an operating manager (non-clinical) and a clinical manager. The clinical manager has been in the role three months and has previous experience in aged care.

The service has addressed nine of 14 shortfalls identified at the previous audit around essential notifications, human resource processes, clinical manager roster, development of care plan within required timeframes, resident/family involvement in care planning, ‘as required’ medication prescribing, restraint monitoring, documentation of infection control measures and bracing of wardrobes against walls.

Further improvements continue to be required around aspects of the quality and risk management systems, consolidation of policies, weight loss management and documentation of interventions.

This audit also identified improvements required around aspects of information on entry, complaints management and open disclosure, guidelines for staffing levels, medication documentation, review of activity plans and review and implementation of risk assessment tools.

Residents and family interviewed spoke positively about the care and support provided at Sylvia Park.

## Audit Summary as at 10 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 |
|  | 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 10 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 10 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 10 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 10 July 2014

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

### Restraint Minimisation and Safe Practice as at 10 July 2014

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

### Infection Prevention and Control as at 10 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. |

# 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:** | Sylvia Park Rest Home Limited |
| **Certificate name:** | Sylvia Park Rest Home Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Sylvia Park Rest Home & Hospital | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 10 July 2014 | **End date:** | 11 July 2014 |

**Proposed changes to current services (if any):**

Two additional bedrooms viewed are suitable for rest home level only. Total bed numbers 81.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 76 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 13 | Total audit hours | 37 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 14 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 73 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 19 August 2014

## **Executive Summary of Audit**

**General Overview**

Sylvia Park rest home and hospital provides care for up to 81 residents at rest home and hospital level of care. Occupancy on the day of audit was 76. There were 44 hospital residents, and 32 rest home residents.   
The owner/facility manager has been operating the facility since 1996 and is supported by an operating manager (non-clinical) and a clinical manager. The clinical manager has been in the role three months and has previous experience in aged care.

The service has addressed nine of 14 shortfalls identified at the previous audit around essential notifications, human resource processes, clinical manager roster, development of care plan within required timeframes, resident/family involvement in care planning, ‘as required’ medication prescribing, restraint monitoring, documentation of infection control measures and bracing of wardrobes against walls.

Further improvements continue to be required around aspects of the quality and risk management systems, consolidation of policies, weight loss management and documentation of interventions.

This audit also identified improvements required around aspects of information on entry, complaints management, and open disclosure, guidelines for staffing levels, medication documentation, and review of activity plans, review and implementation of risk assessment tools.

Residents and family interviewed spoke positively about the care and support provided at Sylvia Park.

**Outcome 1.1: Consumer Rights**

Families are invited to have input in the resident’s initial care plan and on-going care plan reviews. Family contact is documented on the family / relative contact sheet and in the accident / incident forms. Registered nurses (RNs) understand their responsibility to keep families informed. Residents’ meetings are held every two months.

The owner, manager and clinical nurse manager report that they are responsible for ensuring all complaints are fully documented and thoroughly investigated. The clinical manager and owner report that they receive many compliments from residents and families.

Required improvements are identified. Adverse events relating to managing challenging behaviours do not reflect evidence of open disclosure to families. Information provided at entry to residents and family/whanau is not available in the Chinese language, yet the majority of residents and their families are Chinese. Residents whose fees are not subsidised have not been given information in writing explaining eligibility requirements. The complaints process is not being communicated adequately to residents and their families. There is a lack of documentation to reflect complaints being dealt with in a timely manner.

**Outcome 1.2: Organisational Management**

An overarching business plan is in place, which encompasses a quality and risk management framework. The manager and clinical manager are still becoming familiar with this plan. Accidents and incidents, the rate of infection, the safe use of restraint, and hazards are being monitored. The internal audit programme has resumed since the recent appointment of the clinical manager in April 2014. Data collected is trended and analysed by the clinical manager, quality initiatives are being implemented by the service.

Statutory reporting obligations are being met by the service; this is an improvement from the previous audit.

Human resource processes are implemented for staff recruitment, selection, orientation and training and development. New staff are provided with relevant information for safe work practice. The in-service training programme covers relevant aspects of care. External training is supported for the registered nursing staff. This is an improvement from the previous audit.

The clinical manager, who works full-time Monday – Friday, has set hours that are reflected on the staff roster. This is an improvement from the previous audit.

The recently developed business plan has only begun to be implemented by the service and requires a longer history to reflect that the quality management system is embedded into the operations of the service. There is also a lack of evidence to reflect progress that is being made against the quality and risk management programme. Policies and procedures require consolidation. These are improvements that were identified during the last audit. Additional improvements identified during this audit are around guidelines to determine safe staffing levels and staffing levels for the afternoon and night shifts.

**Outcome 1.3: Continuum of Service Delivery**

The sample of residents’ records reviewed provides evidence that the provider has systems to assess and plan care needs of the residents. A registered nurse completes an initial assessment and develops a long term care plan within three weeks of admission. This is an improvement since the previous audit. There is documented evidence of resident/family involvement in the care planning process. This is an improvement since the previous audit. All long term care plans are reviewed six monthly and demonstrate service integration. Risk assessment tools are completed on admission. This is an improvement since the previous audit. Resident files include three monthly review notes by the GP. This is an improvement since the previous audit. The service has implemented new wound assessments and management plans. This is an improvement since the previous audit; however this audit identifies an improvement around aspects of wound care documentation. Improvements remain from the previous audit around the use of short term care plans for short term needs and weight loss management including a weight loss policy and review of dietary profiles. This audit has identified improvements required around the review of risk assessment tools, use of pain assessments, management of challenging behaviour and documentation of interventions to reflect the resident’s current needs.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete annual medication education. There is an improvement required around annual competencies and aspects of medication documentation. The previous finding around route of PRN medications has been addressed. The medication charts are reviewed three monthly by the GP.

The activities programme is facilitated by an activities coordinator and team of activity assistants. Residents and families report satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meets the recreational and cultural preferences and abilities of the consumer groups. There is an improvement required around the review of activity plans.   
All food and baking is done on site. There is an Asian and European menu daily. The two yearly dietitian review of the menu is in process. Dietary profiles are completed on admission and resident likes/dislikes are known to the cooks. Choices are available and are provided. Meals are well presented. Food services staff have received food safety and hygiene training.

**Outcome 1.4: Safe and Appropriate Environment**

The building holds a current warrant of fitness. Electrical equipment is checked annually. All medical equipment is calibrated and all hoists and electric beds are checked and serviced. Hot water temperatures are monitored monthly and are at 45 degrees and below. Free standing wardrobes have been braced to the walls. This is an improvement since the previous audit.

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

Restraint practices are used where it is clinically indicated and justified and other de-escalation strategies are ineffective. Restraint policies and procedures include definitions, processes and use of enablers. There are six residents using a restraint in the form of bedrails and no residents using enablers. For residents who are using a restraint, the frequency of monitoring the restraint is documented on the restraint consent form, on the monitoring form and in the resident’ care plans. This is an improvement from the previous audit.

**Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The registered nurse is the infection control co-ordinator. The Infection Control co-ordinator is part of the quality committee group. Reports and surveillance data are discussed at staff meetings. All staff receive infection control education on orientation and attend annual education. Infection and infection control measures are documented in the care plans of residents suffering from infections. This is an improvement since the previous audit.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 9 | 0 | 5 | 4 | 0 | 0 |
| **Criteria** | 0 | 30 | 0 | 10 | 3 | 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 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 58 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Information is provided at entry to residents and family/whanau in English, although the majority of residents and their families speak Chinese (link 1.1.13).  Adverse events relating to managing challenging behaviours do not reflect evidence of open disclosure to families (sighted for five incidents where challenging behaviour was exhibited and there was no evidence that families were kept informed) (link 1.3.6).  Residents and their families, whose fees are not subsidised, have not been given information in writing explaining eligibility requirements. | Ensure Pre-entry information on services is available in English and Chinese languages.  Ensure families are kept informed of adverse events relating to managing challenging behaviours.  As per the requirements of the ARC contract, ensure that all non-subsidised residents and their family are issued with a copy of The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know’ on entry to the service. | 90 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Five of eight resident satisfaction survey responses indicate that the residents do not under the complaints process and the service is not meeting their expectations regarding dealing with complaints. Written information is provided in English only at entry to the service explaining the complaints process. This information is not made available for the resident and/or family to retain. | Ensure residents understand their right to lodge a complaint and that their expectations are met when dealing with a complaint, including keeping them fully informed. Information relating to the complaints process needs to be readily available to residents and families. | 90 |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Verbal complaints received are not lodged in the complaints register. Nor is there evidence of any follow-up actions taken and / or verbal complaints being closed.  There is evidence of one written complaint that was received on 8 Oct 2013 by the son of one of the residents. There is a lack of evidence that this complaint was acknowledged or that the complainant was kept informed of the outcome of the complaint. There is a sticky note on the file ‘to reply to family’ but there is no evidence that this was done. | Ensure there is documented evidence of complaints being acknowledged, investigated, and that the complainant is kept informed of the investigation and outcome of the complaint. | 90 |
| HDS(C)S.2008 | Standard 1.2.1: Governance | The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low |  |  |  |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.1 | The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | The clinical manager was appointed in April 2014. Prior to her appointment, there were gaps in the quality management system. The clinical manager understands the concepts of continuous quality improvement but has not yet fully implemented the Sylvia Park Quality Management Programme. | Ensure managers understand the new quality and risk management system. Internal audits are to be completed as per the internal audit schedule. | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Low | The clinical manager has yet to reconcile all hard copy policies and procedures with the electronic version of policies and procedures. This was identified as an area for improvement during the last audit. | Ensure there is one set of documented policies and procedures for the service | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.7 | A process to measure achievement against the quality and risk management plan is implemented. | PA Low | The business plan (effective in January 2014) lists goals for the service. This plan is linked to the quality and risk management frameworks for the service. The clinical manager and the manager have not developed any processes to reflect progress and achievements towards meeting the goals of the service. | Ensure there is the regular review of the business plan goals to monitor progress that is being made against the quality and risk management programmes. | 90 |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Guidelines to determine safe staffing levels have not been documented. Staffing levels are inadequate for the afternoon and night shifts. | Ensure residents are provided with adequate numbers of staff to ensure their safety. | 30 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (1) There are no short term care plans or interventions documented for a) rest home resident with XXXX and monitoring requirements, b) two hospital residents with recent weight loss. There is no evidence of weight loss monitoring. Both residents did not have a monthly weigh from October 3013 to February 2014. There is no weight loss management policy in place and c) rest home resident with acute left calf pain and suspected deep vein thrombosis (DVT). (2) Four of 15 wound care plans do not document the required frequency for change of dressings/evaluations. One skin tear short term care plan has not been evaluated for 17 days. Pressure area interventions are not documented on the care plan for one hospital resident with a XXXX. (3) Pain assessments have not been completed for, a) one rest home resident with XXXX on analgesia, b) rest home resident with chronic pain XXXX, c) Hospital resident with chronic pain XXXX, d) hospital resident with lower back pain, e) hospital resident XXXX being managed with analgesia; (4) The dietary profile has not been updated to reflect, a) additional dietary requirements for two hospital residents with weight loss, and b) the XXX status of one rest home resident. (5) One rest home resident with XXXXX does not have alternative strategies/activities documented. A disturbing assessment has not been completed. | Ensure interventions are documented to meet the resident’s current needs. | 60 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Activity evaluations are not co-ordinated with the care plan review. | Ensure the activity plan is reviewed at the same time as the care plan review. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | Two out of six resident files sampled (two rest home) do not evidence six monthly reviews of risk assessments as follows; a) no review of continence, oral assessment, falls risk, pain and continence assessment for one rest home resident and b) dietary profile for a rest home resident. The resident risk profile has not been amended for two hospital residents to reflect a change a high falls risk. 2) One rest home resident has not had a review of XXXX plan since August 2013. The same resident has not had a review of their XXXXX plan to include the addition of XXXX medication and optimal blood sugar levels. | 1) Ensure risk assessments are reviewed at least six monthly or earlier if resident needs change. 2) Ensure specific care plans and risk profile are amended to reflect resident current needs. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | 1) The pharmacy has not completed a six monthly stocktake of controlled drugs. 2) Alternative therapies are not identified on the medication chart. 3) Two of 12 medication charts did not have photo identification. | 1) Ensure six monthly pharmacy stocktake of controlled drugs is undertaken. 2) Ensure alternative therapies are identified on the medication chart. 3) Ensure all medication charts have photo identification. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Six of 12 RNs have not completed an annual medication competency. | Ensure annual medication competencies are completed. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | The self-medication assessments for residents administering Chinese herbal medicines have not been reviewed three monthly. | Ensure self-medication assessments are reviewed a least three monthly. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The setting is family-orientated with relatives who regularly visit the residents. Families are invited to have input in the resident’s initial care plan and on-going care plan reviews. Family contact is documented on the family / relative contact sheet and accident / incident forms. Registered nurses (RNs) understand their responsibility to keep families informed. Relatives interviewed confirm they are kept informed. Residents’ meetings are held two-monthly.

Information is provided at entry to residents and family/whanau. The Sylvia Park Welcome Booklet is handed to families to read but is not issued to them. It is only available in English although the majority of residents and their families speak Chinese (link 1.1.13).

Adverse events relating to falls reflects evidence that families are kept informed. But adverse events relating to managing challenging behaviours do not reflect evidence of open disclosure to families

D16.4b Access to interpreter services is identified, includes language support and access to the DHB. Sylvia Park has multi-cultured staff and residents, registered nurses and caregivers described being able to interpret for residents when needed.

D12.1 The manager was unaware that non-Subsidised residents needed to be advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

D16.1b.ii 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.

D11.3 The information pack can be printed in a large font and can be read to residents.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The setting is family-orientated with relatives who regularly visit the residents. Families are invited to have input in the resident’s initial care plan and on-going care plan reviews. Family contact is documented on the family / relative contact sheet and accident / incident forms. Registered nurses understand their responsibility to keep families informed. Residents’ meetings are held two-monthly, which are facilitated by the activities staff.

Adverse events relating to falls reflects evidence that families are kept informed. But adverse events relating to managing challenging behaviours do not reflect evidence of open disclosure to families (sighted for five incidents where challenging behaviour was exhibited) (link 1.3.6).

Information is provided at entry to residents and family in English although the majority of residents and their families speak Chinese (link 1.1.13).

Eligibility for subsidies are determined by an assessment completed by Needs Assessment and Service Coordination (NASC). The manager reports that some residents are ineligible for funding and pay privately for services. He was unaware that non-Subsidised residents and their families need to be advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

**Finding:**

Information is provided at entry to residents and family/whanau in English, although the majority of residents and their families speak Chinese (link 1.1.13).

Adverse events relating to managing challenging behaviours do not reflect evidence of open disclosure to families (sighted for five incidents where challenging behaviour was exhibited and there was no evidence that families were kept informed) (link 1.3.6).

Residents and their families, whose fees are not subsidised, have not been given information in writing explaining eligibility requirements.

**Corrective Action:**

Ensure Pre-entry information on services is available in English and Chinese languages.

Ensure families are kept informed of adverse events relating to managing challenging behaviours.

As per the requirements of the ARC contract, ensure that all non-subsidised residents and their family are issued with a copy of The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know’ on entry to the service.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The owner, manager and clinical nurse manager report that they are responsible for ensuring all complaints are fully documented and thoroughly investigated. The clinical manager and owner report that they receive many compliments. If a verbal complaint is received, it is dealt with in a prompt manner but is not recorded in the complaints register regardless of the nature of the complaint.

D13.3h.The complaints procedure is provided to resident/relatives at entry in the Sylvia Park Welcome Booklet, which is available in English only (link 1.1.9). This booklet is handed to families to read but is not issued to them. A complaints audit was conducted by the clinical manager in June 2014 identifying that the complaints information was not obvious to residents and families. The corrective action included posting the Health and Disability Code of Rights, written in Chinese, in every resident room (note: an English version was placed in the one resident’s room who identifies as European).

A complaints folder is held in the clinical manager’s office. Included in the folder is the complaints register, the complaints procedure, and a complaints flow chart. A complaints form is also held in the complaints folder. Meetings minutes documented for May and June 2014 provide evidence of verbal complaints received.

Examples include a family complaining that they are doing the resident’s care and staff are reluctant to help, a resident who was outside and XXXXX, and a daughter complaining that staff have been too rough with a resident. These complaints are not documented in the complaints register. Nor is there documented evidence of what follow-up actions were taken to deal with these complaints.

The complaints register has only one lodged complaint documented. On XXXX a resident’s son wrote to complain that his mother was not able to get staff to give her a glass of water. The caregiver was asked to respond to this complaint in writing (sighted). There was no evidence that the complainant was kept informed of the investigation or of the outcome of the complaint.

Eight residents’ surveys, which were completed in June 2014 identified that five of eight residents do not understand the complaints process and the service is not meeting their expectations regarding dealing with complaints. Interviews with five residents (three rest home level and two hospital level) and one family failed to identify this issue although this can possibly be attributed to a language barrier and residents not feeling comfortable discussing their concerns with the auditors. A translator (on site RN) was used to assist with the interviews.

##### **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:** PA Low

**Evidence:**

The residents’ rights are displayed in Chinese in the resident rooms. There is one resident whose rights are documented in English in his room. Posters on the Code of Health and Disability Consumers’ Rights are in locations throughout the facility. Information regarding the complaints process is provided to residents and their family at admission in the Welcome Booklet but this information must be handed back to the manager after reading (link 1.1.9). Five of eight resident satisfaction survey responses indicate that the residents do not understand the complaints process and the service is not meeting their expectations regarding dealing with complaints.

**Finding:**

Five of eight resident satisfaction survey responses indicate that the residents do not under the complaints process and the service is not meeting their expectations regarding dealing with complaints. Written information is provided in English only at entry to the service explaining the complaints process. This information is not made available for the resident and/or family to retain.

**Corrective Action:**

Ensure residents understand their right to lodge a complaint and that their expectations are met when dealing with a complaint, including keeping them fully informed. Information relating to the complaints process needs to be readily available to residents and families.

**Timeframe (days):** 90 *(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:** PA Low

**Evidence:**

A complaints folder is held in the clinical manager’s office. Included in the folder is the complaints register, the complaints procedure, and a complaints flow chart. A complaints form is also held in the complaints folder. Meetings minutes documented for May and June 2014 provide evidence of verbal complaints received. Examples include a family complaining that they are doing the resident’s care and staff are reluctant to help, a resident who was outside and incontinent by the school, and a daughter complaining that staff have been too rough with a resident. These complaints are not documented in the complaints register. Nor is there documented evidence of what follow-up actions were taken.

The complaints register has only one lodged complaint documented. On XXXX a resident’s son wrote to complain that his mother was not able to get staff to give her a glass of water. The caregiver was asked to respond to this complaint in writing (sighted). There is a lack of evidence that the complainant was kept informed of the investigation or of the outcome of the complaint

**Finding:**

Verbal complaints received are not lodged in the complaints register. Nor is there evidence of any follow-up actions taken and / or verbal complaints being closed.

There is evidence of one written complaint that was received on XXXX by the son of one of the residents. There is a lack of evidence that this complaint was acknowledged or that the complainant was kept informed of the outcome of the complaint. There is a sticky note on the file ‘to reply to family’ but there is no evidence that this was done.

**Corrective Action:**

Ensure there is documented evidence of complaints being acknowledged, investigated, and that the complainant is kept informed of the investigation and outcome of the complaint.

**Timeframe (days):** 90 *(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:** PA Low

**Evidence:**

This aged care facility provides care for up to 81 residents. Two rest home level rooms have been added since the last audit. There is written evidence of this being communicated to the portfolio manager at Auckland District Health Board. Seventy-six residents were living in the facility during the audit which included 44 hospital residents and 32 rest home residents.

The service has a strategic plan and quality/business plan for the service which is dated 6 January 2014. Included in the business plan is a quality policy framework, mission and philosophy. Strategic goals are listed. Nursing objectives have been defined by the service. The risk management framework identifies risks and management controls. Also identified is the person(s) responsible. The previous strategic plan (2012 – 2014) has been archived and is no longer applicable. This is an improvement from the previous audit.

The owner has owned Sylvia Park since 2004. She is supported by a manager with a background in accounting, a clinical nurse manager, registered nursing staff and caregiver staff. The current clinical nurse manager (registered nurse) was recently appointed in April 2014. She was previously employed as a clinical manager in another aged care facility in Auckland for the past six years.

The ADHB funding manager has assigned a registered nurse with aged care experience who is providing consulting support to the facility. This individual comes on site every two-three weeks. Meeting minutes are held that reflect her input. She was contacted by the auditor to request an interview but was unavailable.

ARC,D17.3di (rest home), D17.4b (hospital), The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. She attended the three day 2013 Aged Care conference in Auckland and regularly attends training provided by ADHB. She recently attended an Aged Related Residential Care Facility Managers’ Forum and Workshop on Collaboration, Education and Vision (four hours).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The quality and risk management plan was developed in January 2014. The clinical manager, who was appointed in April 2014 has begun an internal audit programme and has also implemented a number of quality initiatives but is still becoming familiar with the new quality system.

Policies and procedures are held in hard copy and electronically. They were last reviewed and updated in 2013 by the previous clinical manager (hard copy reviews only). This includes the clinical nursing manual, kitchen and food services manual, administrative manual, and the residents’ rights manual. The newly appointed clinical manager reports that not all electronic policies align with the hard copy policies. She is gradually reconciling all hard copy documents with the electronic files and linking policies to evidence-based practice. This identified improvement from the last audit remains.

Management meeting include meeting regularly with an aged care consultant who was assigned by the portfolio manager from the Auckland District Health Board. The agenda template outlines discussion items. Management meeting minutes were sighted for 2013 and 2014. This is an improvement from the previous audit. Gaps in meeting minutes were identified during the period of time when there was no clinical manager employed. RN meetings and staff meetings are held monthly (meeting minutes sighted). Meeting minutes reflect evidence of discussions relating to accidents and incidents, infections, internal audit results, quality initiatives, and corrective actions

Incidents and accidents are reported on an incident and accident form and recorded on a monthly summary sheet. An infection rate monthly summary is completed. All hazards are reported on a hazard form. Restraint and enabler usage is documented and monitored. All quality data is collated by the clinical nurse manager for analysis and review.

The new quality system has recently been implemented for the service. This includes the implementation of quality initiatives and implementation of an internal audit programme. Gaps in quality monitoring occurred during a period of time when there was no clinical manager on site (Oct 2013 – March 2014). Recent quality initiatives include monthly weights (June 2014); facility presentation (April 2014); chart order (April 2014), monitoring the call system (June 2014), and placing new shelves in the clinical mangers office to accommodate files. Internal audits conducted in 2014 (beginning March 2014) include; six week follow-up after admission; cleaning; complaints procedure; individual care plans; laundry services; kitchen food service; medication; use of restraint compliance; resident care/hygiene/ safety and infection control. Each completed audit includes an outcome score. Where corrective actions are identified, when completed, they are dated and signed off by the clinical manager. Examples of corrective actions undertaken in 2014 include placing information on the patient code of rights in residents’ rooms (link 1.1.13); cleaning requirements; installing a clothesline and providing a laundry worker with updated education on soaking soiled clothing; addressing resident’s by their preferred names. Staff and RN meetings provide a forum to feedback to staff the results of the internal audits and discuss required improvements.

A resident satisfaction survey was recently completed (June 2014). Surveys were distributed to residents and families. Eight completed surveys were returned. Residents have expressed their dissatisfaction with the complaints process (link 1.1.13.1). The clinical manager reports that corrective actions will be developed based on the survey results received.

Staff interviews with five of five caregivers, three of three RNs, two cooks, and four activities staff confirm their understanding of the corrective action process. They report that they are kept informed of quality improvements and are asked for their feedback. They also report that the service is focussed on quality and that there is good teamwork amongst staff.

The health and safety manual was last reviewed by the clinical manager on 11 June 2014. Health and safety policies are linked to the Health and Safety in Employment Act 1992. The manager is the appointed health and safety officer. He has received external health and safety education. He reports that there have been no reported employee accidents. Safety audits are scheduled to be completed three-monthly by the clinical manager although they have not yet been undertaken. A form for identifying hazards is in place. A hazard register is in place, which is held in the health and safety manual.

D10.1 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.

D19.2g: Falls prevention strategies are in place including sensor mats, falls risk assessments, physiotherapy input, exercise programmes, environmental audits, use of and staff training on manual handling. An excessively high number of falls that occur on the PM and night shifts has been identified by the clinical manager and in the accident and incident trending reports. Corrective actions include hiring additional registered nurse (RN) and caregiver staff for the afternoon and night shifts, once approved by the owner.

D19.3 There are implemented health and safety policies and procedures in place including accident and hazard management.

##### **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:** PA Low

**Evidence:**

The business plan, which includes the components of quality and risk management was developed in January 2014. The manager and the clinical manager, who was appointed in April 2014, are becoming more familiar with this plan. The clinical manager has begun an internal audit programme and has also implemented a number of quality initiatives but the quality system has not been fully implemented (e.g., not all internal audits have been completed as per the internal audit programme). The goals of the service are listed under the categories of consumer focus, provision of effective programmes, certification and contractual requirements, and risk management. Goals are linked to the internal audit programme, resident satisfaction, professional development including mandatory training, complaints and incidents and accidents. These goals were developed in January 2014 as evidenced on the footer section of the business plan.

**Finding:**

The clinical manager was appointed in April 2014. Prior to her appointment, there were gaps in the quality management system. The clinical manager understands the concepts of continuous quality improvement but has not yet fully implemented the Sylvia Park Quality Management Programme.

**Corrective Action:**

Ensure managers understand the new quality and risk management system. Internal audits are to be completed as per the internal audit schedule.

**Timeframe (days):** 180 *(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:** PA Low

**Evidence:**

Policies and procedures are held in hard copy and electronically. This includes the clinical nursing manual, kitchen and food services manual, administrative manual, and the residents’ rights manual. They are readily available to staff in the office area. They were last reviewed and updated in June 2013 by the previous clinical manager (hard copy reviews only). The newly appointed clinical manager reports that electronic policies do not consistently align with the hard copy policies and procedures. She is gradually reconciling all hard copy documents with the electronic files and linking policies to evidence-based practice. This identified improvement from the last audit remains.

**Finding:**

The clinical manager has yet to reconcile all hard copy policies and procedures with the electronic version of policies and procedures. This was identified as an area for improvement during the last audit.

**Corrective Action:**

Ensure there is one set of documented policies and procedures for the service

**Timeframe (days):** 180 *(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:** PA Low

**Evidence:**

The business plan (effective in January 2014) lists goals for the service. This plan is linked to the quality and risk management frameworks, defined in the business plan. The clinical manager and the manager have not developed any processes to reflect progress and achievements towards meeting the goals of the service.

**Finding:**

The business plan (effective in January 2014) lists goals for the service. This plan is linked to the quality and risk management frameworks for the service. The clinical manager and the manager have not developed any processes to reflect progress and achievements towards meeting the goals of the service.

**Corrective Action:**

Ensure there is the regular review of the business plan goals to monitor progress that is being made against the quality and risk management programmes.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an accident/incident policy. The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms by the registered nurse. The incidents forms are then reviewed and investigated by the clinical nurse manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to staff meetings, registered nurse meetings and management meetings. Obsolete incident forms have been replaced with current accident and incident forms. This is an improvement from the previous audit.

Twenty seven falls were documented on accident and incident forms for the month of May 2014 and twenty-seven again in June 2014. The clinical manager is aware of this exceptional number of falls and has working on implementing strategies to reduce this number (e.g., assigning a falls champion, ensuring sensor mats are not pushed under the bed, increasing monitoring of the repeat fallers. The majority of falls are during the PM and night shift. Caregivers report that often during the night there is not enough staff working. The clinical manager agrees stating that additional RN and caregiver cover is necessary to reduce the number of falls (link 1.2.8.1).

The clinical manager and manager are aware of their statutory requirements in relation to essential notification. There was a suspected norovirus outbreak earlier this year. The clinical manager reports that both the public health authorities and Auckland District Health Board (ADHB) were notified. The clinical manager is also aware of other essential notification requirements (e.g., serious accident, significant staffing issue, coroner’s inquest). This is an improvement from the previous audit.

A sample of 12 incident/accident forms were reviewed for May 2014. Forms evidence that the next of kin are contacted for falls and bruises but not for episodes of challenging behaviours (link 1.1.9.1). The incident forms reviewed included; 8 falls, two behavioural incidents and two bruises. There is evidence of assessment and first aid provided, registered nurse follow up including neurological observations, development of short term care plans and wound care plans, review of risk assessments, review by GP and referral as appropriate.

D19.3b: 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:**

Seventy-three staff are employed by the service. Six staff files were selected for review (the clinical manager, two registered nurses and three caregivers). There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have signed employment contracts. The practising certificates of all registered nurses are current. The service also maintains copies of other visiting practitioners’ registration including GP, podiatrist and physiotherapist.

Appointment documentation includes reference checks and interviews. There is a training/induction process that describes the management of orientation. New caregivers are paired with experienced caregivers and must demonstrate competency in caring for the residents before being allowed to work independently. Interviews with five of five caregivers confirm that their orientation programme is adequate to meet the needs of the residents. An orientation checklist was sighted in three of three staff files, which includes new staff who have been employed over the past two years. The majority of caregivers hired have previous caregiving experience. The caregivers report that the orientation period can be extended if needed.

There is an annual appraisal process in place. Staff appraisals are current (sighted in six of six staff files). The manager completes appraisals for the caregivers and the clinical manager completes appraisals for the registered nurses.

The service has a training policy and schedule for in-service education. The in service schedule is implemented. Attendance records are maintained. Each session includes an attendance sheet and training content. In-service education is conducted every month. Interviews with five of five caregivers and three of three registered nurses advised that there is access to sufficient training. Registered nurses have separate professional development folders which are current and reflect up-to-date training (sighted in three of three folders). Medication competencies are completed for all nurses who administer medication. Competencies are scheduled to annually but are missing for six out of twelve registered nurses (link 1.3.12.3). There is a minimum of one staff on site twenty-four hours a day, seven days a week who holds a current first aid and cardiopulmonary resuscitation (CPR) certificate (certificates sighted). Education conducted in 2013 - 2014 includes (but is not limited to); residents rights, challenging behaviours, preventing falls, sexuality and intimacy, pain management, communication, restraint minimisation, manual handling, medication management, infection control, dementia and emergency and fire evacuation procedures. Staff who are unable to attend are provided with written information and competency questionnaires to complete. The Career Force education programme has been reintroduced to the facility and is facilitated by an external educator. Caregiver staff have yet to complete their level three Career Force training. Plans are in place to train two registered nurses as Career Force education assessors.

##### **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:** PA Moderate

**Evidence:**

Guidelines to determine safe staffing levels were not available for sighting. The management meeting minutes on 8 May 2014 report that the consultant will provide the service with a set of guidelines for review. This has not been signed off as completed (reviewed 6 June 2014).

The physical environment of the facility reflects residents’ rooms on two floors of the building. The rooms are ample-sized which results in long hallways and some residents significantly distanced from the nursing stations.

There is a registered nurse (RN) on duty 24/7. The clinical manager is scheduled on the roster to work Monday – Friday from 0700 – 1530. She reports that she usually arrives at 0630 and stays until 1600 or until her work is finished for the day. There are three registered nurses on duty on the morning, two registered nurses on the afternoon shifts and one registered nurse on night duty. Based on the current occupancy, the clinical manager reports that on the day shift, each RN is responsible for 38 residents (one on each floor) and the third RN is floating, covering where she is needed. Ten caregivers are rostered for the day shift. The clinical manager reports that this is busy for the staff but is adequate to meet the needs of the residents.

On the PM shift, there are two RNs rostered and eight caregivers. The clinical manager reports that staffing is not adequate during tea time and when putting the residents to bed. During the night shift there is one registered nurse and three caregivers rostered for 76 residents (based on current occupancy). The clinical manager and five of five caregivers report that staffing is not adequate on the PM and night shifts, and that this explains why there are so many residents falling during these two shifts (link 1.2.4). The manager also acknowledges that staffing is inadequate and reports that he plans to add another caregiver for the night shift. Interviews with five residents (three rest home level and two hospital level) and one family report that staffing is adequate although a translator (RN) was used for the interviews and the translator reports that the Chinese residents are not willing to complain to people that they do not know.

At least one staff member on duty holds a current first aid qualification. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment.

##### **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:** PA Moderate

**Evidence:**

Guidelines to determine safe staffing levels were not available for sighting. The management meeting minutes on 8 May 2014 report that the consultant will provide the service with a set of guidelines for review. This has not been signed off as completed (reviewed 6 June 2014).

The physical environment of the facility reflects residents’ rooms on two floors of the building. The rooms are ample-sized which results in long hallways and some residents significantly distanced from the nursing stations.

There is a registered nurse (RN) on duty 24/7. The clinical manager is scheduled on the roster to work Monday – Friday from 0700 – 1530. She reports that she usually arrives at 0630 and stays until 1600 or until her work is finished for the day. There are three registered nurses on duty on the morning, two registered nurses on the afternoon shifts and one registered nurse on night duty. Based on the current occupancy, the clinical manager reports that on the day shift, each RN is responsible for 38 residents (one on each floor) and the third RN is floating, covering where she is needed. Ten caregivers are rostered for the day shift. The clinical manager reports that this is busy for the staff but is adequate to meet the needs of the residents.

On the PM shift, there are two RNs rostered and eight caregivers. The clinical manager reports that staffing is not adequate during tea time and when putting the residents to bed. During the night shift there is one registered nurse and three caregivers rostered for 76 residents (based on current occupancy). The clinical manager and five of five caregivers report that staffing is not adequate on the PM and night shift. [It was also noted an increase in residents falling during these two shifts (link 1.2.4)].

The manager also acknowledges that staffing is inadequate and reports that he plans to add another caregiver for the night shift. Interviews with five residents (three rest home level and two hospital level) and one family report that staffing is adequate although a translator (RN) was used for the interviews and the translator reports that the Chinese residents are not willing to complain to people that they do not know.

At least one staff member on duty holds a current first aid qualification. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment.

**Finding:**

Guidelines to determine safe staffing levels have not been documented. Staffing levels are inadequate for the afternoon and night shifts.

**Corrective Action:**

Ensure residents are provided with adequate numbers of staff to ensure their safety.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D.16.2, 3, 4: The six resident files sampled (three hospital, three rest home) identified that the RN completed an initial nursing assessment with 24 hours and initial care plan within 48 hours. This is an improvement from the previous audit.

Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes and transfer notes from external facilities (where applicable) forms the basis of the nursing assessment and care plan. The resident and their family participate (via a translator if required) in the initial assessment and Nursing Care plan. There is at least one Cantonese/mandarin speaking staff member on duty at all times to provide a communication channel for residents and families. The registered nurse (RN) develops the long term care within the required three week timeframe. This is an improvement since the previous audit. In six of six resident files sampled the nursing long-term care plan is evaluated six monthly.

Allied health professionals involved in the residents care are linked to the nursing care plan such as, dietitian, physiotherapist, and gerontology nurse specialist. There is documented evidence of resident/family participation in the development of the initial care plan and review of long term care plans in six of six resident files sampled.

D16.5e: Six of six resident files sampled identified that the GP had seen the resident within two working days. The GP documents at the three monthly review if the resident is stable, review period and reviews the medication on the drug chart.

The contracted general practitioner (GP) (interviewed) visits the home weekly on Fridays to see patients due for three monthly examination, three monthly medication reviews, visits other residents of concern, initiate referrals and investigations as required. He meets with families to discuss their relative health concerns, tests and results. There is no language barrier. The GP is available for other visits during the week as required and available on his mobile 24/7. The GP states the requests for visits are appropriate and he is satisfied with the RN clinical assessments. The GP is very satisfied with the care the residents receive. He provides a Locum to cover is practice when on leave.

The home has a contracted physiotherapist for 12 hours per week. She carries out mobility and equipment assessments on residents and receives referrals from the RN and GP for resident assessments, exercise programme and post falls assessments. The activity co-ordinators assist with the exercise and walking programme.

Shift handovers take place at the beginning of the shift (observed) and care staff are informed of any changes to resident’s health including changes to mobility status, infections, and outcomes of GP visits. Progress notes are written each shift.

All six resident files sampled identified integration of allied health professionals and a team approach.

Three rest home files were sampled.

Tracer methodology; rest home resident:

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

Tracer methodology; hospital level resident:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.5: 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:**

Six of six resident files sampled evidenced resident/family involvement (by signature) in the development of initial and long term care plans. If family are unable to attend the care plan meeting there is documented evidence on the family/relative contact form of involvement in care plan development. This is an improvement since the previous audit.

##### **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:** PA Moderate

**Evidence:**

Residents long term care plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Short term care plans are available for use to document management of short term needs. The improvement required around the use of short term care plans for short term or acute needs identified at the previous audit remains. Residents (three rest home and two hospital) and one hospital family member state their needs are being met.

D18.3 and 4. All staff report that there is adequate continence supplies and dressing supplies. Supplies of continence and wound care products were sighted in the medication room. Continence assessments are completed on admission as applicable.

There are comprehensive wound assessment, wound care plan, treatment and evaluation forms in use. This is an improvement since the previous audit. The GP review all wounds and pressure areas as evidenced in the GP notes. Photos are taken as required and there are links to allied health identified in the evaluations/care plans. There is a short term care plan in use for skin tears. There are four skin tears, four minor wounds, one chronic wound and three pressure areas (one toe, one heel – both chronic and one hospital acquired grade 2 ). Pressure areas are linked to the care plan. There are no pressure areas interventions documented for one resident with a chronic pressure area (link 1.3.3). There are improvements required around the documentation of the frequency of change of dressings/evaluations for wounds and skin tears.

A range of assessment tools are completed on admission if applicable. This is an improvement since the previous audit. Risk assessment tools include (but not limited to); a) dietary profile b) Coombes falls risk assessment) c) continence urinary and bowel assessment. d) Norton pressure area risk assessment e) pain assessment and Abbey f) wound assessment g) oral assessment and care plan h) disturbing behaviour assessment and i) physiotherapist assessment. There continues to be an improvement required around the review (link 1.3.8.3) and implementation of risk assessment tools where resident needs change.

A recent quality improvement around weight management is in process. Residents are weighed monthly and weights are monitored by the clinical manager and the contracted dietitian who visits the service monthly or earlier as required. The dietitian (interviewed) is involved in the dietary regime for two residents with PEG feeds. The improvement required around weight loss management and weight loss policy, from the previous audit remains. The dietitian (on interview) confirmed she will be reviewing the Asian menu to identify where calorie intake can be increased for residents with weight loss without compromising their cultural food preferences.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Short term care plans are available for use to document management of short term needs.

Residents are weighed monthly and weights are monitored by the clinical manager and the contracted dietitian who visits the service monthly or earlier as required. The dietitian (interviewed) is involved in the dietary regime for two residents with PEG feeds.

There are comprehensive wound assessment, wound care plan, treatment and evaluation forms in use. The GP review all wounds and pressure areas as evidenced in the GP notes. Photos are taken as required and there are links to allied health identified in the evaluations/care plans. There is a short term care plan in use for skin tears. There are four skin tears, four minor wounds, one chronic wound and three pressure areas.

A range of assessment tools are completed on admission if applicable. This is an improvement since the previous audit. Risk assessment tools include (but not limited to); a) dietary profile b) Coombes falls risk assessment) c) continence urinary and bowel assessment. d) Norton pressure area risk assessment e) pain assessment and Abbey f) wound assessment g) oral assessment and care plan h) disturbing behaviour assessment and i) physiotherapist assessment.

**Finding:**

(1) There are no short term care plans or interventions documented for a) rest home resident with XXXXX and monitoring requirements, b) two hospital residents with recent weight loss. There is no evidence of weight loss monitoring. Both residents did not have a monthly weigh from October 3013 to February 2014. There is no weight loss management policy in place and c) rest home resident with XXX). (2) Four of 15 wound care plans do not document the required frequency for change of dressings/evaluations. One skin tear short term care plan has not been evaluated for 17 days. Pressure area interventions are not documented on the care plan for one hospital resident with a XXXXX. (3) Pain assessments have not been completed for, a) one rest home resident XXXXX pain on analgesia, b) rest home resident with chronic pain on XXXX, c) Hospital resident with chronic pain in XXXXXX d) hospital resident with lower back pain, e) hospital resident with XXXX being managed with analgesia; (4) The dietary profile has not been updated to reflect, a) additional dietary requirements for two hospital residents with weight loss, and b) the diabetic status of one rest home resident. (5) One rest home resident with challenging behaviours does not have alternative strategies/activities documented. A XXXXX assessment has not been completed.

**Corrective Action:**

Ensure interventions are documented to meet the resident’s current needs.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The senior Activity Coordinator is employed three days a week. Her role is to; oversee the team of eight activities assistants who all work part-time, co-ordinate the Monday to Saturday and activity programme, ensure adequate resources are available, conduct activity assessments, reviews and complete progress notes. There are three activities co-ordinators on each day including Saturdays. Each activity assistant (three interviewed) bring a set of skills and knowledge to the team such as nursing of the elderly, church involvement and teaching. Activities are offered from 0930am to 3pm and to 5.30pm three afternoons a week. The team communicates daily. They attend all on-site in-service. There are two monthly residents and family meetings. The majority of staff are able to communicate in Mandarin or Cantonese with the residents. Families are very supportive and advocate for the residents as they speak English. Staff interpret meetings and discussions with the residents and families for the activities co-ordinator so that she can carry out activity assessments, review and care planning in consultation with the resident/family. The activities coordinator liaises with the Clinical Manager daily and receives an update on resident health, mobility and cognitive status. There are two smaller lounges upstairs and one downstairs where activities take place at different times during the day. Seated chair exercises are taken daily. The physiotherapist is involved in the exercise programme Many residents enjoy outdoor Tai Chi when the weather permits. Most residents are immersed in the Chinese culture and enjoy crafts and knitting, listening to music and Cantonese opera, poems, hymns, bible reading, prayer, recitals, watching DVD's on their history and culture and reminiscing about their country. Traditional festivities such as Chinese New Year is observed. Community visitors include school children, dance groups, church groups and visiting Buddhists. There are fortnightly van drives. The van has a wheelchair hoist and can accommodate three wheelchairs. Residents enjoy outings to Chinese shopping and goods centres, attending music and entertainment shows. Residents have been taken out on the harbour cruises which have been enjoyed so much (confirmed on interviews) that there are more trips planned. One resident receives one on one time playing chess, reading food and fishing books, walks and enjoys outings. The activity assistants make contact with the resident daily. Multicultural staff ensures residents of other cultures such as Samoan have their recreational needs met. A library area has been set up with Chinese and English library books. The activity co-ordinator is introducing a new format activity plan. Currently spiritual and cultural beliefs and interests are included in the care plan.

D16.5d Resident files reviewed identified that the individual activity plan is not reviewed when 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:** PA Low

**Evidence:**

The activity co-ordinator is introducing a new format activity plan. Currently spiritual and cultural beliefs are included in the care plan. Six monthly activity evaluations are occurring by the activity co-ordinator.

**Finding:**

Activity evaluations are not co-ordinated with the care plan review.

**Corrective Action:**

Ensure the activity plan is reviewed at the same time as the care plan review.

**Timeframe (days):** 90 *(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:** PA Low

**Evidence:**

RN reviews and evaluates the initial care plan at three weeks after admission and the nursing long term care plan every six months. The GP examines the resident at least every three months and reviews the medication. There is an annual resident health care review undertaken by the multidisciplinary team. The six monthly nursing written evaluation is aligned with the identified care plan goals and needs. There is a multidisciplinary approach to the review of care plans. There is an improvement required around ensuring changes to cares/medical conditions are updated on the care plan. Each resident has a risk profile at the front of their individual record. Risk assessment tools are completed on admission however there is an improvement required around the review of risk tool assessments six monthly with the care plan review or earlier if the residents needs change.

D 16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

D 16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

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

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

**Attainment and Risk:** FA

**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:** PA Low

**Evidence:**

The six monthly nursing written evaluation is aligned with the identified care plan goals and needs. There is a multidisciplinary approach to the review of care plans. Each resident has a risk profile at the front of their individual record. Risk assessment tools are completed on admission.

**Finding:**

Two out of six resident files sampled (two rest home) do not evidence six monthly reviews of risk assessments as follows; a) no review of continence, oral assessment, falls risk, pain and continence assessment for one rest home resident and b) dietary profile for a rest home resident. The resident risk profile has not been amended for two hospital residents to reflect a change a high falls risk. 2) One rest home resident has not had a review of oral care plan since August 2013. The same resident has not had a review of their XXXX plan to include the addition of XXX medication and optimal XXXXX.

**Corrective Action:**

1) Ensure risk assessments are reviewed at least six monthly or earlier if resident needs change. 2) Ensure specific care plans and risk profile are amended to reflect resident current needs.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is one locked medication room upstairs where all medication supplies , the Controlled drugs safe and the two locked medication trolleys for the whole complex is kept. The supplying pharmacy (since February 2014) delivers all robotic rolls and pharmaceuticals and collects the returns. A return to pharmacy log is maintained and the returns bin is kept safely within the medication room. PRN medications are dispensed in bottles. Expiry dates and supplies of PRN medications are checked two weekly. The RNs sign off a monthly stock checklist.

The robotic rolls are checked by two registered nurses (RN’s) on delivery medication reconciliation and signed off on the written medication reconciliation form. Any discrepancies are fed back to the supplier. RNs and two senior caregivers are designated to administer medication. An improvement is required around the completion of annual competencies. Medication education is provided annually. There are weekly controlled drug checks evident in the controlled drug register. The checking out and administration of controlled drugs is signed by two medication competent staff. There is an improvement required around six monthly pharmacy controlled drug stocktake. All eye drops/ointments and creams in use had an opening date. GTN sprays in use are within their expiry date. The medication fridge is monitored weekly and recordings sighted. There is a current verification log of staff signatures designated to be medication competent. Standing orders in use are current (May 2014). Verbal order forms are used and the GP signs for this on the drug chart within seven days (sighted). There is one resident who self-medicates an inhaler and the self-medication competency is reviewed by the RN and GP three monthly. There is a resident responsibility declaration and daily signing sheet signed by the resident. There are several other residents who self-medicate herbal Chinese medicines. The medicine is listed on the self-medication assessment and signed by the GP and RN. There is improvement required around self-medication reviews and identification of alternative therapies on the medication chart. Duplicate name labels are used. There are medication cautions and instructions in the medication folder for conditions such as diabetic on insulin, warfarin and other medication guidelines and precautions.

Twelve resident drug charts sampled are pharmacy generated. Administration signing sheets sampled are all correct. The date and time of PRN medications are documented. The route of PRN medications is prescribed by the GP. This is an improvement since the previous audit. 12 of 12 medications charts identified allergies/adverse reaction. There is an improvement required around photo identification on the medication chart.

D16.5.e.i.2; Twelve medication charts sampled identified that the GP had seen the resident 3 monthly and the medication chart was signed.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are weekly controlled drug checks evident in the controlled drug register. The checking out and administration of controlled drugs is signed by two medication competent staff. There is one resident who self-medicates an inhaler and the self-medication competency is reviewed by the RN and GP three monthly. There is a resident responsibility declaration and daily signing sheet signed by the resident. There are several other residents who self-medicate herbal Chinese medicines. The medicine is listed on the self-medication assessment and signed by the GP and RN. There are 10 of 12 medication charts with photo identification.

**Finding:**

1) The pharmacy has not completed a six monthly stocktake of controlled drugs. 2) Alternative therapies are not identified on the medication chart. 3) Two of 12 medication charts did not have photo identification.

**Corrective Action:**

1) Ensure six monthly pharmacy stocktake of controlled drugs is undertaken. 2) Ensure alternative therapies are identified on the medication chart. 3) Ensure all medication charts have photo identification.

**Timeframe (days):** 30 *(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:** PA Low

**Evidence:**

RNs and two senior caregivers are designated to administer medication. Six RNs, two senior caregivers and the clinical manager have completed annual medication competencies. Medication education is provided annually.

**Finding:**

Six of 12 RNs have not completed an annual medication competency.

**Corrective Action:**

Ensure annual medication competencies are completed.

**Timeframe (days):** 30 *(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:** PA Low

**Evidence:**

There are several other residents who self-medicate herbal Chinese medicines. The medicine is listed on the self-medication assessment and signed by the GP and RN.

**Finding:**

The self-medication assessments for residents administering Chinese herbal medicines have not been reviewed three monthly.

**Corrective Action:**

Ensure self-medication assessments are reviewed a least three monthly.

**Timeframe (days):** 90 *(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 cook works from 9am to 6pm. The kitchen hands start at 7am to cook breakfast. All food and meals are prepared on site. The cooks prepare an Asian and English menu daily. The English menu is three weekly rotating and the Asian menu four weekly rotating. Both menus are adjusted to the summer/winter seasons. The menu was last reviewed by a dietitian in 2012. The dietitian (interviewed) confirms she is in the process of reviewing the menu and is also looking at ways in which the menu can be modified to include increase in calorie intake for Asian residents without compromising their cultural dietary preferences. Each resident has a diet profile which includes likes and dislikes. The cook (interviewed) confirmed she is informed of any changes to dietary needs and aware of any resident dislikes. Modified diets including soft, pureed and diabetic are catered for and residents can have a choice of alternative options. Lip plates and easy grip utensils are available to promote independence with meals. Meals are delivered to the several smaller dining areas and served by food services staff. Food is kept hot in bain marie containers. The main dining room is served from the kitchen. Food temperatures are monitored daily. Fridge and freezer temperatures are recorded weekly and there are thermometers in place for visual daily checks.

All food is covered with non-perishable foods in fridges date labelled. The staff are observed wearing correct protective wear - gloves, aprons and hats. There are cleaning schedules (sighted) in place with cleaning duties done at the end of each day. The dishwasher has auto feed chemicals. Chemicals are stored safely. The kitchen is well equipped with two gas ovens and a comb oven. There is good bench space with separate preparing, baking, storage and dishwashing areas.

The kitchen is located off the main dining area and a staff only area with keypad access. All food services staff have completed relevant training. A dietitian is planning education on nutrition in the near future. There are food safety and hygiene policies and procedures in place. Two hospital and three rest home residents stated they are very happy with the meals provided. Residents have the opportunity to provide suggestions and feedback on the menu at two monthly resident meetings.

D19.2 staff have been trained in safe food handling

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building has a current warrant of fitness which expires 9/6/2015. The lift between the levels have been checked as port of the building warrant of fitness. Automatic doors are serviced.

The assistant manager is responsible for ensuring maintenance and repairs are carried out as requested in the maintenance book. Preferred contractors are called for electrical, plumbing, building problems and other repairs if required. There is a preventative maintenance plan. Electrical equipment is tested and tagged. Clinical equipment has been calibrated and checked for function. Hoists have been checked December 2013. The interior and exterior is well maintained. The outdoors areas are easily accessible for residents and provide safe outdoor walking and seating areas. The outdoor furniture is sturdy and umbrellas are provided for shade as required.

Free standing wardrobes have been braced/stabilised against the bedroom walls. This is an improvement since the previous audit.

ARC D15.3; The following equipment is available: electric beds, ultra-low electric beds, pressure relieving mattresses, lifting and standing hoists, chair scales, shower chairs, lifting aids, wheelchairs, walking frames and overbed tables. Interviews with five caregivers and three registered nurses confirm there is adequate equipment to carry out their duties and care safely.

Two additional rest home only bedrooms are viewed and meet the requirements for rest home care. The rooms have hand basins and ensuite and there is adequate space for residents to move around their bed space with the use of mobility aids.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

A restraint coordinator oversees the restraint minimisation and safe practice programme. She is responsible for staff education and training on restraint and enabler use. The most recent in-service (18 June 2014) included 11 attendees. Those that cannot attend training are provided with hand-outs to read. All staff are requested to complete a restraint competency questionnaire. Staff are requested to provide information regarding definitions and appropriate use of restraints and enablers.

The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has six residents on the register using restraint. There are no residents on the register using an enabler. Approved restraints include barriers to prevent residents from getting out of bed (e.g. bedrails).

Two files were reviewed of residents who are using a restraint. There was evidence of a signed consent form, completed restraint assessment and regular evaluations of restraint use. The use of restraint is carried over into the resident’s care plan. The frequency of monitoring the use of restraint is documented on the consent form, on the restraint monitoring form and in the resident’s care plan (sighted in two of two residents’ files). This is an improvement from the previous audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The service currently has three residents with Extended Spectrum Beta Lactamase (ESBL). There are alerts and documented interventions to prevent the spread of infection contained within the resident care plans. Five caregivers interviewed are knowledgeable in infection control procedures and could describe the standard precautions used for the management of residents with ESBL. This is an improvement since the previous audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control co-ordinator is a RN with a defined job description for infection control and has attended an external study day in outbreak management. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to plan and determine infection control activities, resources and education needs within the facility. Resident infections are collated monthly and include respiratory, urinary, skin, gastro-intestinal and wound infections. A monthly analysis of types of infections, trends, corrective actions and quality initiatives is reported to the management, RN and staff meetings. Infection control information including monthly graphs are made available to staff. An infection log is maintained in the medication folder and the GP reviews antibiotic use at the three monthly reviews.

##### **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.)*