# Presbyterian Support Central - Woburn Elderly Care

## Current Status: 11 August 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

Woburn Enliven is part of Presbyterian Support Central (PSC). There are currently 41 of 43 hospital residents, 40 of 42 rest home residents and 22 of 25 dementia residents residing at Woburn. The facility is currently managed by the regional manager with a contract manager due to start to provide interim management until a new manager is appointed. The regional manager is supported by a clinical director, a quality coordinator, a care manager and a supportive registered nurse team. There is an orientation programme being implemented supporting new staff.

The service has addressed three of seven previous audit findings around incident reporting, implementing the in-service education programme, and the odour in the dementia unit. Improvements continue to be required around aspects of the quality management programme, conducting staff appraisals, care plan evaluations and pain management.

This audit has identified improvements are required in relation to completion of unit standards for dementia care staff, wound care documentation, aspects of care planning and restraint documentation.

## Audit Summary as at 11 August 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 11 August 2014

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

### Organisational Management as at 11 August 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 11 August 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 low risk. |

### Safe and Appropriate Environment as at 11 August 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 11 August 2014

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

### Infection Prevention and Control as at 11 August 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:** | Presbyterian Support Central |
| **Certificate name:** | Presbyterian Support Central - Woburn Elderly Care |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Woburn Home | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care) | | | |
| **Dates of audit:** | **Start date:** | 11 August 2014 | **End date:** | 12 August 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 103 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **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** | XXXXX |  |  | **Hours** | 1.5 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 12.5 | Total audit hours | 36.5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 18 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 120 | Number of relatives interviewed | 8 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, 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 Wednesday, 10 September 2014

## **Executive Summary of Audit**

**General Overview**

Woburn Enliven is part of Presbyterian Support Central (PSC). There are currently 41 of 43 hospital residents, 40 of 42 rest home residents and 22 of 25 dementia residents residing at Woburn. The facility is currently managed by the regional manager with a contract manager due to start to provide interim management until a new manager is appointed. The regional manager is supported by a clinical director, a quality coordinator, a care manager (absent on the days of audit) and a supportive registered nurse team. There is an orientation programme being implemented supporting new staff.

The service has addressed three of seven previous audit findings around incident reporting, implementing the in-service education programme, and the odour in the dementia unit. Improvements continue to be required around aspects of the quality management programme, conducting staff appraisals, care plan evaluations and pain management. This audit has identified improvements are required in relation to completion of unit standards for dementia care staff, wound care documentation, aspects of care planning and restraint documentation.

**Outcome 1.1: Consumer Rights**

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. Family members are informed in a timely manner when their family members health status changes. There is a complaints policy and an incident/accident reporting policy. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

**Outcome 1.2: Organisational Management**

The quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. PSC Woburn Enliven has a current business and quality plan to support quality and risk management at each facility. PSC Woburn collates data for comparisons against other PSC homes and with an external benchmarking company. Improvements are required whereby meeting minutes are completed; all internal audits are conducted as per the audit programme and collation of quality information including incident and accident reports are conducted in timely manner. Resident/relative surveys are undertaken annually. Incidents and accidents are appropriately managed with clinical follow up and investigations conducted. The service has made improvements in this area. The service has made improvements with implementing a training plan with compulsory training days provided; however, further improvements are required in relation to completion of unit standards for dementia unit care staff and completion of annual appraisals for staff. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents**.**

**Outcome 1.3: Continuum of Service Delivery**

Registered nurses are responsible for each stage of service provision. A care plan is developed in consultation with the resident and family/whanau where appropriate. Service delivery plans are individualised, up-to-date and reflect current service delivery requirements for each resident. The plans are reviewed at least six monthly for rest home residents and three monthly for hospital residents. Short term support plans are utilised for changes in health status such as infections, fractures and wounds. General practitioners conduct three monthly clinical reviews. Residents interviewed are complimentary about the care provided. Activities are provided that reflect ordinary patterns of life and encourage residents to remain integrated in their community. There are comprehensive medication management policies and procedures in place. Medications are appropriately managed and administered by staff that have completed annual medication competencies. Residents have a nutritional assessment completed on admission and dietary requirements and likes and dislikes are recorded. Special diets are catered for to meet residents' needs and specialist input is accessed as required. The service has made improvements in relation to aspects of service delivery. However pain assessment and management still requires further improvement. Further improvement is also required around wound management for wounds that require treatment after three weeks.

**Outcome 1.4: Safe and Appropriate Environment**

The facility displays a current building warrant of fitness. Improvement has been made in relation to the carpet odour in the dementia unit.

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

There is a restraint policy that includes definitions of restraint and enablers. There are 18 residents assessed as requiring an enabler, and no residents on restraint. Staff are trained in restraint minimisation and managing challenging behaviours. Improvements are required around documenting associated risks to the resident when using enablers and documenting on-going monitoring.

**Outcome 3: Infection Prevention and Control**

The infection control nurse at PSC Woburn completes a monthly infection summary which is discussed at clinical and management meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary including a recent outbreak.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 5 | 1 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 59 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | a) On review of the internal audits it is noted that audits relating to medication management and care planning have not been conducted as per the planner, since May 2013; b) Minutes of the clinical team meeting are recorded by the care manager, however, the last meeting minutes sighted are for March 2014. Hand written notes were evidenced but these have not been produced in to a readable account of the meeting and have not been available for staff; c) Incident reports for the past three months have been completed but not entered on to the data base for collation. | a) Conduct internal audits as per schedule; b) Produce minutes of meetings in a timely manner for staff access; c) Collate all quality data for analysis and to identify opportunities for improvement. | 60 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | a) On review of the training records for care staff working in the dementia unit, it is noted that four of 18 have not completed the unit standards and have been employed for longer than 12 months. Advised by the educator (who has been in the role since April 2014) that the service is working towards ensuring that all staff have completed the unit standards within the required time frames; b)Advised that the manager conducts annual performance appraisals, however, seven of eight appraisals could not be located (one recently employed staff member). | a) Ensure all care staff who work in the dementia unit commence and complete dementia unit standards within the required timeframes; b) ensure that annual staff appraisals are conducted. | 90 |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | (i) Three residents (one rest home, one hospital and one dementia) do not show documented evidence of weight management and one rest home resident does not show documented evidence of behaviour monitoring. (ii) Short term support plans are in place for fourteen wounds (seven rest home and seven hospital) that require long term intervention. | (i) Ensure that all residents support plans are updated to reflect interventions that meet the needs of the residents. (ii) Ensure that all wounds being treated after three weeks are transferred to a chronic/complex wound treatment plan. | 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 1.3.8.2 | 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. | PA Low | Four of eight support plans (one rest home and three hospital) do not show documented evidence of three monthly evaluation. | Ensure that all residents’ support plans are reviewed at least three monthly. | 90 |
| 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 | Three residents (two hospital and one rest home) do not show evidence that pain assessments have been reviewed and monitored following administration of PRN analgesia. | Ensure that pain management is evaluated including assessments and monitoring as required. | 90 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | (i) Two of six files reviewed did not show evidence of monitoring. (ii) All six files reviewed did not show evidence of risks associated with enablers documented in the residents support plan. | (i) Ensure that all residents using enablers have ongoing documented monitoring. (ii) Ensure that all residents using enablers have risks associated with enablers documented in the residents support plan. | 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:** FA

**Evidence:**

The service has an open disclosure policy stating residents and /or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Eight residents (four rest home and four hospital) and eight family members (one rest home, five hospital and two dementia) stated they were welcomed on entry and were given appropriate time and explanation about services and procedures. Resident/relative meetings occur six monthly. Advised by the regional manager and registered nurses that they have an open-door policy. Interpreter services are accessible via the local DHB.

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

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

D16.4b Eight family members stated that they are always informed when their family members health status changes.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Complaint forms and a copy of the complaints process is available in the reception area waiting room. An electronic complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. All individual complaints (written and verbal) are documented or scanned on to the computer. There has been one complaint for 2014 which was reviewed and one complaint from 2013 which was reviewed. Both complaints reviewed evidenced appropriate documentation and management. The 2013 complaint remains open as the service’s response and investigation is currently being reviewed by the Health and Disability Commissioner. The electronic complaints folders and register is kept up to date with evidence of follow up and resolution. There is evidence of advocacy support for complainants. Seven care workers, five registered nurses, one quality coordinator and one regional manager confirm that all complaints are reported and recorded. Complaints are reported and discussed at senior team management meetings and to the organisation.

Resident and family satisfaction survey was conducted in December 2013 with residents and families advising that they were more than satisfied with the care and services they receive.

D13.3h. a complaints procedure is provided to residents within the information pack at entry

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Woburn Enliven is part of the Presbyterian Support Central (PSC) organisation. The service provides rest home, hospital and dementia level care for up to 110 residents in a 25 bed dementia unit (the Court), 42 bed rest home wing and a 43 bed hospital wing. There are five dual purpose rooms in the rest home area. On the day of the audit there were 103 residents - 40 rest home, 41 hospital residents and 22 dementia. The service has a quality and risk management system which continues to require some improvements. The organisation has committed resources with a designated quality coordinator/educator. The facility is in the process of appointing a new manager – the currently role is being filled by the regional manager. The regional manager has the responsibility of providing oversight to seven of the 14 PSC facilities. Advised that a contract manager has been engaged to provide oversight of the facility until such time as a new permanent placement has been found. The contract manager commences her role next week. The service has a care manager (registered nurse) who oversees the clinical care of the facility. The care manager was absent on the days of audit. Presbyterian Support Central has a documented mission statement, vision, values, corporate commitment and older person’s services goals. Woburn’s business plan 2013 - 2014 includes analysis, service profile and a number of time framed goals for quality / service improvements. The service has a structure that supports the continuity of management and quality of care and support (including staff management). The facility is supported by an experienced care manager registered nurse (RN), a quality coordinator, senior registered nurse team and support also occurs via a PSC clinical director.

##### **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:**

There is a current business, quality and risk management plan for 2013 - 2014. The quality plan includes goals relating to a quality improvement system, respecting the individual values and beliefs and rights of residents, operating in a safe environment for residents and staff, and to provide effective clinical care. The plan includes the goals, expected measures and results achieved in progressing towards the goals. The plan is reviewed three monthly with a report sighted for the July 2013 – June 2014 period. The service has continued implementing their quality and risk management system since previous certification; however, further improvements are required in some areas. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at Woburn. There is a designated quality coordinator who has been in the role since early June 2014. The manager provides a monthly report to central office (permanent role currently vacant). The PSC regional manager provides oversight for the facility at present with a contract manager due to commence until a new, permanent manager is appointed.

PSC Woburn has a senior management team that includes key staff from all areas of the service and a clinical team. The senior management team meeting includes areas for health and safety, infection control, clinical, chaplain, recreation, education, restraint and projects update. Staff interviewed were able to discuss the quality systems and Eden philosophy / approach.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

Previous certification audit identified that improvements were required around collection and reporting of quality information to staff. This continues to require improvement. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. PSC has reviewed the quality structure of its service to include quality reporting within all areas. There is an internal audit schedule, meetings calendar and education plan for 2014. On review of the internal audits it is noted that audits relating to medication management and care planning have not been conducted as per the planner. Improvements are required in this area. Staff meetings are held each month in each unit (rest home, hospital and dementia unit meetings all held last on 16 July 2014). Discussion occurs around health and safety, equipment, and management and clinical reports are presented from their respective meetings. There is a senior management team meeting held weekly with discussion on occupancy, reports from each area (housekeeping, rest home, dementia and hospital), resident status, and corrective actions from internal audits (minutes viewed for 23 July 2014). A clinical management team meeting is held every two weeks and discussion occurs around infections, resident clinical issues, quality issues, and policies for review. Minutes of this meeting are recorded by the care manager; however, the last meeting minutes sighted are for March 2014. Improvements are required in this area.

Policies and procedures cross-reference other policies and appropriate standards.

There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule.

D5.4: The service has policies/ procedures to support service delivery.

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 is a comprehensive infection control manual as well restraint policy and health and safety policy/procedures.

Monthly accident/incident reports are completed by the registered nurses and care manager with collation of data and entry on to an electronic spread sheet conducted by the quality coordinator. These are also compared with last month. The monthly reports are provided to staff via meetings and staff notice boards. Advised that QPS benchmarking indicator results (that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents) has been conducted in the past but the service is behind in collecting this data. Incident reports for the past three months have been completed but not entered on to the data base for collation. Improvements are required in this area.

Health and safety monthly report is completed and presented to the senior management team meeting. The report includes identification of hazards and Incidents and accidents reporting and trends identified.

The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. Results are sent to PSC approval group for analysis. The restraint coordinator completes a monthly report which is tabled at the quality committee.

Internal audits conducted in 2014 include activities, restraint, fire drill, food services, laundry, nutrition, pressure area, pain, personnel files, complaints, incidents, and education. The range of meetings include: staff, senior management team, residents, health and safety, registered nurses and Eden Associates. These meetings and quality reports provide the means to measure achievement of the implemented quality and risk system. Quality improvement processes are in place to capture and manage non-compliances, internal audits and corrective actions. The quality coordinator monitors corrective actions. Reports are tabled and discussed at meetings. The service establishes corrective actions in response to data and other inputs. Corrective actions identify responsibilities and timeframes for completion. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Internal audits identify key issues for improvement, and an action plan that has been implemented and followed up. The service has addressed and monitored this previous finding. A hazard register is established that includes a hazard register for all areas of the facility. There is also an implemented hazard monitoring form that is implemented for environmental inspections.

There is documented evidence that the service quality goals are discussed and progress to meeting the goals are reviewed at the senior management team meeting and clinical team meeting. A resident/relative survey was conducted in December 2013 via QPS with overall satisfaction reported on the care and services provided by the service.

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

D19.2g fall prevention strategies such as environmental hazards review, mobility and transferring assessment, foot wear review, falls risk assessments.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Previous certification audit identified that improvements were required around collection and reporting of quality information to staff. This continues to require improvement. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. PSC has reviewed the quality structure of its service to include quality reporting within all areas. There is an internal audit schedule, meetings calendar and education plan for 2014. Internal audits conducted in 2014 include activities, restraint, fire drill, food services, laundry, nutrition, pressure area, pain, personnel files, complaints, incidents, and education. Staff meetings are held each month in each unit (rest home, hospital and dementia unit meetings all held last on 16 July 2014). Discussion occurs around health and safety, equipment, and management and clinical reports are presented from their respective meetings. There is a senior management team meeting held weekly with discussion on occupancy, reports from each area (housekeeping, rest home, dementia and hospital), resident status, and corrective actions from internal audits (minutes viewed for 23 July 2014). A clinical management team meeting is held every two weeks and discussion occurs around infections, resident clinical issues, quality issues, and policies for review. The range of meetings include: staff, senior management team, residents, health and safety, registered nurses and Eden Associates. These meetings and quality reports provide the means to measure achievement of the implemented quality and risk system. Monthly accident/incident reports are completed by the registered nurses and care manager with collation of data and entry on to an electronic spread sheet, conducted by the quality coordinator. These are also compared with the previous months. The monthly reports are provided to staff via meetings and staff notice boards. Advised that QPS benchmarking indicator results (that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents) has been conducted in the past but the service is behind in collecting this data.

**Finding:**

a) On review of the internal audits it is noted that audits relating to medication management and care planning have not been conducted as per the planner, since May 2013; b) Minutes of the clinical team meeting are recorded by the care manager, however, the last meeting minutes sighted are for March 2014. Hand written notes were evidenced but these have not been produced in to a readable account of the meeting and have not been available for staff; c) Incident reports for the past three months have been completed but not entered on to the data base for collation.

**Corrective Action:**

a) Conduct internal audits as per schedule; b) Produce minutes of meetings in a timely manner for staff access; c) Collate all quality data for analysis and to identify opportunities for improvement.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is entered on to a spread sheet for collation and analysis (link #1.2.3.6) the QPS benchmarking service is available to the service but is not currently being utilised other than for resident/relative survey. Incident/accidents are documented; reporting of incidents occurs and are monitored with action taken on trends to improve service delivery. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service documents family contact following an incident. A sample of 18 incident reports for June 2014 were reviewed (relating to skin tears, falls, medication errors, behaviours, bruising, pressure areas and other), all were completed and documented that family were notified as per instructions. Incident reports related to dementia residents (three), rest home residents (three), and hospital (six). There was evidence in progress notes that family/next of kin have been contacted. Clinical follow up is conducted by a registered nurse with further investigations conducted by the senior RN, care manager and/or manager. Incident reporting audit was conducted in June 2014 with 98% compliance achieved. The previous certification audit identified that incident forms reviewed were incomplete. The service has addressed and monitored this previous finding.

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

**Evidence:**

Woburn PSC employs 120 permanent full time and part time staff. There are appropriate human resource policies and procedures in place for staff recruitment, training and support including staff recruitment policy, recruitment interviewing guidelines, interview questions, termination of employment policy, staff orientation policy with orientation pack and competencies, Police vetting form, staff conduct policy and form - signed by staff on commencement of employment and a non-disclosure of information form. Individual employment agreements or collective agreement letters of employment were sighted in eight of eight staff files reviewed. There are job descriptions available for all positions and staff advised that they have employment contracts. Eight staff files were reviewed and included three registered nurses (one from each unit), four care workers (one rest home, one hospital and two dementia) and one cook. The previous audit identified that annual appraisals had not been completed for all staff. Advised that the manager conducts annual performance appraisals, however, seven of eight appraisals could not be located (one recently employed staff member). Improvements continue to be required in this area. The regional manager is currently responsible for recruitment of staff. On review of one recently employed care worker’s file, there is evidence of documented reference checking. A copy of qualifications and annual practising certificates including registered nurse and general practitioners is kept and these were sighted for all GP's, pharmacists, dietitian, podiatrist and all registered nurses. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The orientation policy and programme includes care staff, cleaning, laundry, kitchen and registered nursing staff. Orientation includes infection control, health and safety, fire and evacuation, house rules, code of conduct and dress code, and responsibilities. Care workers (seven) and registered nurses (five) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One recently employed staff member had completed the orientation programme.

The previous audit identified that the compulsory training sessions had not been well attended. There is a staff training policy and a staff performance monitoring policy. Discussion with the registered nurses and care workers confirm that the service provides in-service training and education that covers relevant aspects of care and support and meets requirements. The education programme includes compulsory training days for care workers and registered nurses which are run each month. The programme alternates each year with year one (2013): restraint and challenging behaviour, abuse and neglect, fire safety, hazards and security, infection control and hand washing, cultural and spiritual safety, residents rights and advocacy and year two (2014): fire and evacuation, ageing process, intimacy and sexuality, communication and Eden philosophy, infection control and hand washing, restraint and challenging behaviour, safe food handling, wounds and medication. On review of the compulsory attendance records for 2013 and 2014 there were 60 attendees at the training days in 2013 and 56 attendees at training days so far for 2014. Manual handling and first aid are also compulsory. Understanding dementia session was also held in August 2013. The service has made improvements in this area.

The annual training programme exceeds eight hours annually. Care workers interviewed (seven) advised that they have either completed the ACE programme or an equivalent qualification. The service provides career force training for care workers and this includes training around dementia. On review of the training records for care staff working in the dementia unit, it is noted that four of 18 have not completed the unit standards and have been employed for longer than 12 months. Advised by the educator (who has been in the role since April 2014) that the service is working towards ensuring that all staff have completed the unit standards within the required time frames. Improvement is required.

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

**Evidence:**

There are job descriptions available for all positions and staff advised that they have employment contracts. Eight staff files were reviewed and included three registered nurses (one from each unit), four care workers (one rest home, one hospital and two dementia) and one cook. The previous audit identified that annual appraisals had not been completed for all staff. The annual training programme exceeds eight hours annually. Care workers interviewed (seven) advised that they have either completed the ACE programme or an equivalent qualification. The service provides career force training for care workers and this includes training around dementia. Registered nurses participate in peer reviews, study days and advanced life support training.

**Finding:**

a) On review of the training records for care staff working in the dementia unit, it is noted that four of 18 have not completed the unit standards and have been employed for longer than 12 months. Advised by the educator (who has been in the role since April 2014) that the service is working towards ensuring that all staff have completed the unit standards within the required time frames; b)Advised that the manager conducts annual performance appraisals, however, seven of eight appraisals could not be located (one recently employed staff member).

**Corrective Action:**

a) Ensure all care staff who work in the dementia unit commence and complete dementia unit standards within the required timeframes; b) ensure that annual staff appraisals are conducted.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support for rest home, hospital and dementia residents. The facility runs as three separate units – with five beds in the rest home designated as dual purpose. The rest home and hospital wings are adjacent with connecting corridors, and the dementia unit is situated in a secure area. Minimum staffing levels over night include one registered nurse on duty in the hospital area; two care workers on in the dementia unit, two in the rest home and two in the hospital area. There is at least one registered nurse on duty at all times. During week days there is a care manager who oversees all areas, a senior registered nurse in the rest home and a senior registered nurse in the dementia unit. The regional manager currently provides managerial oversight for the facility and shares his time with six other facilities in the PSC district. There are designated staff for kitchen, laundry, cleaning and activities. Residents interviewed (eight - four rest home and four hospital) and family members (one rest home, two dementia and five hospital), advised that there is sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to resident’s needs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The registered nurses at PSC Woburn are responsible for development of the care plan with input from the care workers. The initial support plan is developed within 24 hours of admission. The assessment and support planning policy describes; guidelines for resident assessment, initial support plan, resident support plan, short-term care plan, evaluation, medical reviews, and interdisciplinary reviews. Evaluations and reviews are completed by the registered nurse (# link 1.3.8.2). Continuing assessments are completed within one week of admission and the long term support plan is developed within three weeks. Assessments include pressure area risk, falls risk, nutrition, pain, behaviour, mobility, continence and social and medical history. Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the support plan. Communication with family is documented. A verbal handover occurs at the end of each shift. There is also a communication book. Staff are informed of any support plans that have been updated at handover.

Seven caregivers interviewed (who work across all shifts and all wings) describe a verbal handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes are written at the end of each shift. Registered nurses document on a health summary sheet where there are any health issues or changes. Any issues arising from quality meetings and resident meetings are communicated to staff (# link 1.2.3.6). The registered nurses inform staff of any changes to residents' care following visits from the general practitioner or other allied healthcare personnel and also documents this information in residents' progress notes and support plans (# link 1.3.6.1). Eight of eight resident files (four rest home and four hospital) identify integration of allied health personnel and a team approach is evident.

Input from a number of allied health personnel is evident in all eight files reviewed including physiotherapist, activity staff, podiatrist and dietitian.

Communication with family is documented in the progress notes. One family member (from the dementia unit) stated they were involved in assessment, care planning and review of the support plans. There are currently 37 wounds being managed at PSC Woburn. Staff training on wound management occurred in 2014.

D16.2, 3, and 4: Eight of eight files reviewed identified that an assessment was completed within 24 hours by a registered nurse. The registered nurses cover all shifts with at two on morning shift, one - two on afternoon and one on during the night.

D16.5e: Eight resident files reviewed identified that the general practitioner had seen the resident within two working days of admission with three monthly (and as needed) reviews. Three monthly medication reviews by a general practitioner is documented in the medical notes section of seven of eight residents' files reviewed (one hospital resident has been at the service less than three months). A care plan is developed within three weeks of admission and is signed and dated by the registered nurse. GP interviewed advised that the staff are prompt to notify her of changes in health status of residents and that they provide excellent resident centred care.

A range of assessment tools where completed in resident files on admission and completed at least three monthly for all residents including (but not limited to); pressure area risk, weight, skin, continence, falls risk, dietary and nutrition, behaviour, mobility and pain.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

All eight support plans viewed (three rest home, three hospital and two dementia) are completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with the GP, seven care workers, five registered nurses, two registered nurses, one regional manager, eight residents (four rest home and four hospital) and eight family members (one rest home, five hospital and two dementia). Support plans include the following sections: hygiene and grooming, mobility, nutrition/fluids, skin and pressure area care, elimination, emotional wellbeing, loneliness, rest and sleep, communication, spirituality, faith and culture, and medical. Short-term support plans are used for acute or short-term changes in health status.

Resident’s needs are assessed prior to admission and have the services of the house Doctor - or their own GP if they prefer. There is evidence of referrals to specialist services such as community psychiatric nurse, dietitian, physiotherapist, podiatry. The service could describe links with other services such as the hospice, needs assessment and other services working with residents.

The facility is in the process of appointing a new manager and the regional manager is currently in this position. There is a care manager for 40 hours per week and registered nurse cover 24 hours a day. Policies and procedures and internal audits are reviewed. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by the registered nurse. Support plans are goal oriented and reviewed at least three monthly for all residents (# link 1.3.8.2). Residents support plans are updated with changes in health status as evidence in four of eight support plans reviewed. Three residents (one rest home, one hospital and one dementia) do not show documented evidence of weight management and one rest home resident does not show documented evidence of behaviour monitoring. This is an area requiring improvement. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation. There is a programme of activities in place and residents are able to access the community and associated services and support. There is a resident care manual. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

All eight files reviewed contained a continence assessment and interventions were documented in the resident's support plans. Specialist continence advice is available as needed and this could be described by staff. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

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

Continence management in-services and wound management (2014) in-service have been provided as part of the compulsory training days for care workers and registered nurses.

Wound assessment and wound management plans are in place for 27 residents (10 rest home and 17 hospital) with wounds (37 wounds currently being treated 13 rest home and 24 hospital). Documented wounds include skin tears, abrasions, nail infections, bruises, haematomas and redden areas. There are five pressure areas being treated in the hospital (three grade one heel pressure areas, one grade one hip pressure area and one chronic complex sacral pressure area with wound specialist involvement). There is one grade one sacral pressure area being treated in the rest home. Short term support plans are used initially for all wounds. Wounds still being treated after three weeks are required to be transferred to a chronic/complex wound treatment plan. Short term support plans are in place for fourteen wounds (seven rest home and seven hospital) that require long term intervention. This is an area requiring improvement.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

All eight support plans viewed (three rest home, three hospital and two dementia) are completed comprehensively. Support plans are goal oriented and reviewed at least three monthly all residents. Residents support plans are updated with changes in health status as evidence in four of eight support plans reviewed. (ii) Wound assessment and wound management plans are in place for 27 residents (10 rest home and 17 hospital) with wounds (37 wound currently being treated 13 rest home and 24 hospital). Short term support plans are used initially for all wounds.

**Finding:**

(i) Three residents (one rest home, one hospital and one dementia) do not show documented evidence of weight management and one rest home resident does not show documented evidence of behaviour monitoring. (ii) Short term support plans are in place for fourteen wounds (seven rest home and seven hospital) that require long term intervention.

**Corrective Action:**

(i) Ensure that all residents support plans are updated to reflect interventions that meet the needs of the residents. (ii) Ensure that all wounds being treated after three weeks are transferred to a chronic/complex wound treatment plan.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are three recreation officers who work 30 hours per week each with another part time staff member working at least six hours per week. There is one recreation officer in the rest home, one in the hospital and one in the dementia unit (has almost completed the diversional therapy training.) Activities are planned that are appropriate to the capabilities of residents and meet with the Eden philosophy and principles. Each area has its own programme and there is interaction between the areas. Recreation officers are rostered to cover the weekends. On admission the recreation officer completes an activity social profile documenting resident’s social history, likes and dislikes and past and present interests. The individual recreation plan is completed within three weeks. Residents are able to participate in an exercise programme (as part of the facility's falls prevention initiative), quizzes, beauty therapy, one to one activities, outings, church services, visiting entertainment, movie nights, gardening, bowls, reminiscing, crafts, music and a variety of activities to maintain strength and interests. Participation in activities is voluntary. Daily attendance records for each resident is kept. The service has volunteers to assist with activities.

The activities programme is developed monthly and covers seven days per week. There are van outings each week and a driver accompanies the recreation officer on outings. The recreation officers have a current first aid certificate. The residents receive a printed copy of the weekly programme. This can be enlarged for those residents who are visually impaired. Copies of the programme are also displayed on the notices boards. Eight resident files reviewed (three rest home, three four hospital and two dementia) contained an assessment and recreation support plan. Eight residents interviewed (four hospital and four rest home) are satisfied with the programme, and find it varied enjoyable and fun. Activities take place in lounges and outside when the weather permits. Residents are able to provide feedback and suggestions for activities at the resident meetings which are held quarterly. Results of resident satisfaction survey completed in December 2013 record positive outcomes.

D16.5d Eight of eight resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review (# link 1.3.8.2)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

All initial support plans were developed by a registered nurse on day of admission and resident support plans developed within three weeks of admission. Support plans are evaluated on a three monthly basis or if there is a change in health status by the registered nurse with input from the care workers and family. A review of eight support plans (three rest home, three hospital and two dementia) evidenced four of eight support plans (two rest home and two dementia) show documented evidence of three monthly evaluation. This is an area requiring improvement. Three residents (two hospital and one rest home) do not show evidence that pain assessments have been reviewed and monitored following administration of PRN analgesia. This was a shortfall identified in the previous certification audit and this is still requires further improvement. There is a general practitioner (as described on interview) review every three months and on an as required basis. The previous audit identified improvements were required around recording de-escalation techniques in the residents support plans. This audit evidences that this finding has now been addressed as sighted in two dementia files reviewed. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out her instructions, giving her full confidence in the management of the residents.

Short term support plans are in use for changes in health status and are recorded on a problem page. Examples sighted are cares required for wounds, continence, cellulitis, behaviours, infections and return from acute care.

D16.4a Support plans are evaluated three monthly for all residents or more frequently when clinically indicated.

D16.3c: All initial support plans are evaluated by a registered nurse within three weeks of admission. The long term care plan is developed 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:** PA Low

**Evidence:**

All initial support plans were developed by a registered nurse on day of admission and resident support plans developed within three weeks of admission. Support plans are evaluated on a three monthly basis or if there is a change in health status by the registered nurse with input from the care workers and family.

**Finding:**

Four of eight support plans (one rest home and three hospital) do not show documented evidence of three monthly evaluation.

**Corrective Action:**

Ensure that all residents’ support plans are reviewed at 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 1.3.8.3 (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:**

Support plans are evaluated on a three monthly basis or if there is a change in health status by the registered nurse with input from the care workers and family

**Finding:**

Three residents (two hospital and one rest home) do not show evidence that pain assessments have been reviewed and monitored following administration of PRN analgesia.

**Corrective Action:**

Ensure that pain management is evaluated including assessments and monitoring as required.

**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:** FA

**Evidence:**

The service uses two weekly robotic sachets for the administration of medications at PSC Woburn. Sixteen medication charts were reviewed and all medication charts have photo ID’s.

There is a signed agreement with the pharmacy. Sachet medications are checked on arrival by two registered nurses, a verification form is completed and signed and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication trolleys and medications are stored in a treatment room. There are three treatment rooms, one in the rest home, one in the dementia unit and the main one in the hospital. There are five medication trolleys, one in the dementia unit and two in each of the rest home and hospital areas. Controlled medications are stored in the main treatment room in the hospital in a locked safe.

There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. The manager holds a list of specimen signatures and competencies

In the hospital there are two locked safes and two Controlled Drug Registers for the safekeeping and administration of controlled drugs. One safe and register is used for stock controlled drugs and the other safe and register is used for individual residents controlled drugs. These drugs are checked on arrival and on administration. Controlled drugs are checked by the Pharmacist and two registered nurses on arrival; the hospital retains a small amount of stock controlled drugs for palliative care, these are checked weekly as per records reviewed and sighted.

The registered nurses are responsible for administration to hospital residents. Registered nurses and senior caregivers who have completed medication competencies administer medication to rest home residents and residents in the dementia unit. Medication competencies are completed annually for all staff administrating medications. The service has not completed a medication management audit as per the audit planner (# link 1.2.3.6). Medication errors are identified and the facility has developed a process for staff management of medication errors which outlines all types of medication errors and corrective action to be taken. The facility has a policy on self-administration of medications which includes a three monthly competency review for residents. There are currently no residents self-administering medications at PSC Woburn. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Charts are easy to read and current. Staff monitor the medication fridge weekly (sighted). Medication management education last provided in 2014 as part of the compulsory training days for care workers and registered nurses. Three registered nurses were observed safely administrating medications (one in the rest home, one in the hospital and one in the dementia unit). Eye drops on all three trolleys were dated on opening.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

PSC Woburn has a large well equipped kitchen. All food is cooked on site. There is a food services manual that ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. A tour of the kitchen noted cleanliness and order in the pantry and fridges complying with guidelines. The service employs a services coordinator who oversees the cleaning, laundry and kitchen services. There is one fulltime chef and two cooks who work alternate weekends. There are two kitchen hand shifts 7am-3pm and 3pm-6pm daily. All staff have food safety certificates (NZQA). Food safety update was provided for all staff in November 2012.

All fridges and freezer temperatures are recorded daily on the recording sheet which was sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily. Dry food stuffs are stored in a storage area in the kitchen. All food was covered and stored on shelving above floor level.

A nutritional profile for each resident is completed on admission and updated at care plan review. There is a likes and dislikes folder maintained in the kitchen for individual resident preferences. There is an external provider dietitian available for individual resident need. The menu is designed and reviewed by a PSC registered dietitian in April 2014. The six weekly menu is varied with evidence of review. Diets are modified as required and currently the kitchen is providing a gluten free diet, a vegetarian diet and a liquid diet for three residents. Staff were observed to assist residents with their meals and drinks and the service has modified plates and cutlery. Residents are weighed monthly or more frequently if required (with exceptions link #1.3.6.1). Eight residents interviewed were very complimentary about the food provided and like the variety of the menu. Resident satisfaction survey which includes food was completed in December 2013 and showed overall satisfaction with the food service. Kitchen staff meetings are held as required.

##### **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:** Not Audited

**Evidence:**

The service displays a current building warrant of fitness which expires on 22 June 2015

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Previous certification audit identified a finding around the smell of urine noticeable in the dementia unit. During a tour of the facility and subsequent visits to the unit over the course of the audit, the smell of urine was not detected. Cleaning audit conducted in August 2013 with 85% compliance and laundry audit was completed in February 2014 with 93% compliance. Carpet cleaning is conducted and a carpet cleaning internal audit was conducted in October 2013 with 85% compliance. The service has made improvements in this area

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

# 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:** PA Low

**Evidence:**

There is a restraint minimisation and safe practice policy is applicable to the service. The policy states that “restraint is the intentional restriction of a person’s voluntary movement or behaviour by the use of a device, medication, physical hold or force for the purpose of controlling the residents escalating or unusual behaviour (challenging behaviour or wandering). The policy states that ‘enabler is the term applied to equipment such as bedrails, noodles, bed wedges, lap/thigh belts, used to promote the independence, comfort and safety of the resident. The service does not have any residents on restraint according to the policy. All resident are currently on enablers. The policy includes an enabler protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. Enabler assessment tools are completed for residents requiring bedside rails, lap belts and thigh belts. The policy includes comprehensive enabler procedures. The process of assessment and evaluation of enabler use is included in the policy. There are 18 hospital residents with 20 enablers in use. Enablers include 15 bedrails, two lap belts and three thigh belts. On review of six hospital resident with enablers, there is evidence of assessment, consent obtained and three monthly evaluation. Enabler monitoring is documented in the care plans and in the progress notes as evidenced in four of the six files reviewed. This is an area requiring improvement. All six files reviewed do not show evidenced of documented risks associated with enabler use. This is an area requiring improvement. Staff have received education on restraint minimisation and challenging behaviour management in 2013 and 2014 as part of the compulsory training days for care workers and registered nurses. An in-service on understanding dementia was provided in August 2013. On interview seven care workers were knowledgeable about restraint minimisation and alternatives and in managing challenging behaviours.

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

**Evidence:**

The policy includes an enabler protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. Enabler assessment tools are completed for residents requiring bedside rails, lap belts and thigh belts. The policy includes comprehensive enabler procedures. The process of assessment and evaluation of enabler use is included in the policy. There are 18 hospital residents with 20 enablers in use. Enablers include 15 bedrails, two lap belts and three thigh belts. On review of six hospital resident with enablers, there is evidence of assessment, consent obtained and three monthly evaluation. Enabler monitoring is documented in the care plans and in the progress.

**Finding:**

(i) Two of six files reviewed did not show evidence of monitoring. (ii) All six files reviewed did not show evidence of risks associated with enablers documented in the residents support plan.

**Corrective Action:**

(i) Ensure that all residents using enablers have ongoing documented monitoring. (ii) Ensure that all residents using enablers have risks associated with enablers documented in the residents support plan.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC co-coordinator (rest home senior registered nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and the laboratory that advises and provides feedback /information to the service. Infections are reported via standard definitions, and are then recorded on an individual infection reporting form. Short term support plans have been developed for use with residents with infections and a flow chart for management of infections has been developed.

The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility. Infection control data is collated monthly and reported to the monthly clinical management meeting. The meetings include the monthly IC report and QPS quarterly results as available. All infections are documented on the infection monthly register and forwarded to a central register for PSC. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. An infection control audit which included hand hygiene was completed in October 2013 with 75% compliance and re-audited in February 2014 with 95% compliance following implementation of corrective actions. Results of surveillance and audits are communicated to staff via management meetings, clinical meetings (link #1.2.3.6), staff meetings, at handover time and via information and graphs posted in the staff room. The service had a gastrointestinal outbreak in March 2014 which was limited to 15 residents and five staff. Regional public health service was notified and provided assistance and follow up.

##### **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.)*