

# Elsdon Enterprises Limited - Ashlea Grove

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Current Status: 4 August 2014

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

## General overview

Ashlea Grove rest home is privately owned and employs a nurse manager who has been in the role since February 2014. The nurse manager is supported by care staff and the service has just employed an enrolled nurse. The service provides rest home and dementia specific level care for up to 37 residents, in a 15 bed dementia unit and 22 bed rest home area. There were 26 residents accommodated on the day of audit, 15 dementia and 11 rest home. A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home and extends the dementia unit by three rooms; the dementia unit now includes 15 residents.

This audit has identified improvements required in maintaining residents privacy, communication with family following incidents, informed consent, reviewing and updating policies, conducting internal audits as per the schedule, completion of satisfaction surveys, conducting meetings as per the schedule, recording on-going hazards, notifying authorities of residents change of level of care, availability of clinical cover, ensuring that staff have signed job descriptions, reference checks and orientation is completed, ensuring staff appraisals are completed annually, ensuring that all staff working in the dementia unit have completed dementia training, delivery of the education programme to include mandatory training, completion of resident risk assessment, reviews, evaluation and care plans, completion of medication competencies and medication documentation, recording of food temperatures and keeping food hot, chemical storage, calibration of medical equipment, repairs of bathrooms, appropriate environment to eliminate urine smells, environmental restraint, infection control documentation and maintaining best practice for infection prevention and control measure.

## Audit Summary as at 4 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

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

### Consumer Rights as at 4 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.		Some standards applicable to this service partially attained and of low risk.
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### Organisational Management as at 4 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.
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### Continuum of Service Delivery as at 4 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 medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 4 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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## Restraint Minimisation and Safe Practice as at 4 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 medium or high risk and/or unattained and of low risk.
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## Infection Prevention and Control as at 4 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.		Some standards applicable to this service partially attained and of low risk.
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## Audit Results as at 4 August 2014

### Consumer Rights

Full information is provided on entry to residents and family/representatives. Family are involved in initial care planning and receive on-going feedback. Residents' values, beliefs, dignity and privacy are respected however improvements are required around maintaining privacy and informed consent. A complaints register is in place. The service has documented complaints and there is evidence of follow up, action and resolution. The complaints register reviewed included verbal complaints. There is an improvement required around notification of incident/accidents to family in a timely fashion.

### Organisational Management

Ashlea Grove rest home has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The service is privately owned and is managed by a nurse manager with considerable experience in aged care.

The facility is guided by a comprehensive set of policies and procedures. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. There are improvements required around reviewing and updating of policies, completion of internal audits, conducting meetings, completion of satisfaction surveys, hazard reporting, business and quality plan completion, clinical service availability, reporting of adverse events, job descriptions, orientation, reference checks, staff appraisals and providing mandatory education.

The induction and education and training programmes for the staff ensure staff are competent to provide care. There is also improvement required around completion of dementia specific training for care givers working in the dementia unit.

## **Continuum of Service Delivery**

Residents are assessed prior to entry to the service. Initial assessment processes to be completed on admission, requires improvement. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the nurse manager who also has the responsibility for maintaining and reviewing care plans. Improvements are required whereby all residents have a plan of care in place. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Improvements are required whereby all long term care plans are evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to conducting risk assessments for all residents. A range of activities are available in both rest home and dementia units and rest home residents provide feedback on the programme. The medication management system includes policy and procedures that requires review. Staff responsible for medication administration receive training. Resident medications are reviewed by the residents' general practitioner at least three monthly. Improvements are required in relation to medication administration documentation, administration practices, and secure storage and medication competencies for staff. Ashlea Grove has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Improvements are required in relation to closer monitoring of fridge, freezer and hot food temperatures, and aspects of safe food practices.

## **Safe and Appropriate Environment**

Ashlea Grove has a current building certificate that expires on 12 July 2015. Scheduled and reactive maintenance is carried out. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. In the rest home there is a lounge and dining area. In the dementia unit there is a lounge and separate dining room. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. The service has extended the dementia unit to include three extra rooms. A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home. The three rooms, communal spaces and toilet facilities are able to cater for three extra dementia care residents.

There is a designated laundry which includes storage of cleaning and laundry chemicals. Improvements are required in relation to the securing of chemicals in the dementia unit. Hot water temperatures are monitored and recorded. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. An improvement is required in relation to carpet odour in one dementia bedroom. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Appropriate policies are available along with product safety charts. There are emergency plans in place and emergency drills have been held. There is an improvement around ensuring six monthly drills are

completed. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. There is an improvement required around ensuring a gas bottle is available for the BBQ.

### **Restraint Minimisation and Safe Practice**

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there was one dementia resident assessed as requiring restraint and no enablers. The restraint is only used as a last resort and is managed appropriately including assessment, consent, care planning and monitoring. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually. Improvements are required whereby environmental restraint is not imposed on rest home residents.

### **Infection Prevention and Control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is required to be reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Improvements are required around reporting of all infections, documentation, reviewing and follow up of infections, ensuring there is a supply of disposable hand towels and appropriate storage of towels in bathrooms.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	Elsdon Enterprises Limited
<b>Certificate name:</b>	Elsdon Enterprises Limited - Ashlea Grove
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Ashlea Grove Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	<b>Start date:</b> 4 August 2014 <b>End date:</b> 5 August 2014

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

A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home and extends the dementia unit by three rooms. The dementia unit now includes 15 residents.

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	26
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## Audit Team

<b>Lead Auditor</b>	XXXXXX	<b>Hours on site</b>	14	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXXX	<b>Total hours on site</b>	14	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	28	Total audit hours off site	16	Total audit hours	44
Number of residents interviewed	5	Number of staff interviewed	9	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	14	Total number of staff (headcount)	22	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	2			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	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 4 September 2014

## Executive Summary of Audit

### General Overview

Ashlea Grove rest home is privately owned and employs a nurse manager who has been in the role since February 2014. The nurse manager is supported by care staff and the service has just employed an enrolled nurse. The service provides rest home and dementia specific level care for up to 37 residents, in a 15 bed dementia unit and 22 bed rest home area. There were 26 residents accommodated on the day of audit, 15 dementia and 11 rest home. A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home and extends the dementia unit by three rooms, the dementia unit now includes 15 residents.

This audit has identified improvements required in maintaining residents privacy, communication with family following incidents, informed consent, reviewing and updating policies, conducting internal audits as per the schedule, completion of satisfaction surveys, conducting meetings as per the schedule, recording on-going hazards, notifying authorities of residents change of level of care, availability of clinical cover, ensuring that staff have signed job descriptions, reference checks and orientation is completed, ensuring staff appraisals are completed annually, ensuring that all staff working in the dementia unit have completed dementia training, delivery of the education programme to include mandatory training, completion of resident risk assessment, reviews, evaluation and care plans, completion of medication competencies and medication documentation, recording of food temperatures and keeping food hot, chemical storage, calibration of medical equipment, repairs of bathrooms, appropriate environment to eliminate urine smells, environmental restraint, infection control documentation and maintaining best practice for infection prevention and control measure.

### Outcome 1.1: Consumer Rights

Full information is provided on entry to residents and family/representatives. Family are involved in initial care planning and receive on-going feedback. Residents' values, beliefs, dignity and privacy are respected however improvements are required around maintaining privacy and informed consent. A complaints register is in place. The service has documented complaints and there is evidence of follow up, action and resolution. The complaints register reviewed included verbal complaints. There is an improvement required around notification of incident/accidents to family in a timely fashion.

### Outcome 1.2: Organisational Management

Ashlea Grove rest home has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The service is privately owned and is managed by a nurse manager with considerable experience in aged care. The facility is guided by a comprehensive set of policies and procedures. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. There are improvements required around reviewing and updating of policies, completion of internal audits, conducting meetings, completion of satisfaction surveys, hazard reporting, business and quality plan completion, clinical service availability, reporting of adverse events, job descriptions, orientation, reference checks, staff appraisals and providing mandatory education.

The induction and education and training programmes for the staff ensure staff are competent to provide care. There is also improvement required around completion of dementia specific training for care givers working in the dementia unit.

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

Residents are assessed prior to entry to the service. Initial assessment processes to be completed on admission, requires improvement. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the nurse manager who also has the responsibility for maintaining and reviewing care plans. Improvements are required whereby all residents have a plan of care in place. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Improvements are required whereby all long term care plans are evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to conducting risk assessments for all residents. A range of activities are available in both rest home and dementia units and rest home residents provide feedback on the programme. The medication management system includes policy and procedures that requires review. Staff responsible for medication administration receive training. Resident medications are reviewed by the residents' general practitioner at least three monthly. Improvements are required in relation to medication administration documentation, administration practices, and secure storage and medication competencies for staff. Ashlea Grove has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Improvements are required in relation to closer monitoring of fridge, freezer and hot food temperatures, and aspects of safe food practices.

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

Ashlea Grove has a current building certificate that expires on 12 July 2015. Scheduled and reactive maintenance is carried out. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. In the rest home there is a lounge and dining area. In the dementia unit there is a lounge and separate dining room. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. The service has extended the dementia unit to include three extra rooms. A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home. The three rooms, communal spaces and toilet facilities are able to cater for three extra dementia care residents.

There is a designated laundry which includes storage of cleaning and laundry chemicals. Improvements are required in relation to the securing of chemicals in the dementia unit. Hot water temperatures are monitored and recorded. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. An improvement is required in relation to carpet odour in one dementia bedroom. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Appropriate policies are available along with product safety charts. There are emergency plans in place and emergency drills have been held.



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	PA Low			
HDS(C)S.2008	Criterion 1.1.3.1	The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.	PA Low	There is one toilet in the dementia unit that does not have a door only a curtain and one toilet in the rest home that does not have a lock or a sign to indicate the toilet is being used.	Ensure there are doors on all toilets with locks or signs to indicate in use or vacant to maintain privacy of residents.	90
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	In the sample of incident reports reviewed and on review of six resident files, there is a lack of documented evidence that family are informed of residents' incidents, accidents in nine of 11 files reviewed.	Provide clear evidence that family are communicated with following incidents, accidents.	90
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		choice are provided with the information they need to make informed choices and give informed consent.				
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	There was no informed consent form signed for one rest home resident and one dementia resident.	Obtain written documentation in relation to informed consent for all residents.	90
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 1.2.3.3	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.	PA Moderate	(i) Not all policies have been reviewed and updated two yearly as documented in the policy review policy. (ii) The service does not have a policy on skin management and the self-medicating policy does not state that a resident requires a three monthly competency check.	(i) Ensure that all policies are reviewed two yearly. (ii) Ensure that the service has a policy on skin management and that the policy on self-medication is updated to included competency reviews three monthly as per the medicines care guide for residential aged care.	90
HDS(C)S.2008	Criterion 1.2.3.5	Key components of service delivery shall be explicitly linked to the quality management system.	PA Moderate	(i) The annual satisfaction survey for 2013 could not be located during the audit and therefore results unable to be sighted. (ii) There	(i) Ensure that satisfaction surveys are collated and analysed and results reported. (ii), (iii) and (iv) Ensure that meetings are held as	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>have been no residents meetings since January 2014. (iii) Staff meetings have not been held three monthly as scheduled. (iv) Management meetings have not been held three monthly as scheduled; (v) The business and quality plan for 2014/2016 is in draft form only.</p>	<p>scheduled; (v) Ensure that the business and quality plan is signed off and implemented</p>	
HDS(C)S.2008	Criterion 1.2.3.6	<p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>On review of the completed audits for 2013 year-to-date, it is noted that not all audits have been complete as per the audit schedule. Scheduled audits not completed include care planning (February 2014), complaints (March 2014), environment and equipment (March 2014), restraint (March 2014), continence (April 2014), medication (April 2014), privacy and safety (April 2014), cultural and spiritual (May 2014), infection (May 2014) and admissions (June 2014).</p>	<p>Ensure that all audits are completed as per the audit schedule.</p>	90
HDS(C)S.2008	Criterion 1.2.3.9	<p>Actual and potential risks are identified,</p>	PA Low	<p>There is no evidence that the hazard</p>	<p>Ensure all new hazards are entered</p>	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(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;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		register is updated as new hazards are identified	onto the hazard register when identified.	
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	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.	PA High			
HDS(C)S.2008	Criterion 1.2.4.2	The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting	PA High	a) One resident in the rest home area XXXXXX <i>This information has been deleted as it is specific to the health care of a</i>	Ensure that essential reporting is conducted and that relevant authorities are notified of changes in the care levels of residents	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and the correct authority is notified where required.		<p><i>resident.</i></p> <p>b) XXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i></p> <p>c) One respite resident  XXXXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i></p> <p>d) One resident living in the rest home  XXXXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i></p>	residing at Ashlea Grove rest home including DHB and HealthCERT. The service is required to ensure that all residents receive care and services appropriate to their assessed needs.	
HDS(C)S.2008	Criterion 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.	PA Moderate	There is no documented evidence that the registered nurse manager has reviewed two residents following a falls incident.	Ensure that the registered nurse manager reviews all residents following incidents and that this is documented.	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 Moderate			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	(i) Two of seven staff files do not show evidence of signed job descriptions. (ii) Two of seven staff files do not show evidence of reference checks. (iii) Four staff files do not show evidence that performance reviews have been conducted annually.	(i) Ensure that all staff have signed job descriptions. (ii) Ensure that all staff have reference checks completed prior to employment. (iii) Ensure that performance reviews are completed annually.	90
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Two from seven staff files reviewed do not show evidence that an orientation programme has been completed.	Ensure that all staff complete and orientation programme.	90
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 Moderate	(i) Training for code of rights, continence, manual handling, hoist use and chemical safety has not been provided in the last two years. (ii) Fire drills have not been conducted six monthly. (iii) Four of sixteen caregivers have not completed dementia standards within the appropriate time frame.	(i) and (ii) Ensure that required training is conducted within the appropriate time frame and that fire drills are conducted six monthly. (iii) Ensure that staff completed dementia standards within the appropriate time frame.	90
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.2.8.1	There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	(i) There is a senior caregiver on call Friday and Saturday who makes clinical decisions. (ii) The caregiver from the dementia unit leaves the unit at night to assist the rest home caregiver attend to a resident in the rest home who requires two person assist to turn the resident (# link 1.2.4.2). (iii) A caregiver, usually from the rest home, is also required to respond to calls from the eight cottages owned by the council. In ii) the dementia unit is left unattended while iii) would see the rest home left unattended..	(i) Ensure that there is access to a registered nurse on call at all times for clinical decisions. (ii) and (iii) Ensure that there is enough staff on duty to maintain a staff presence in the dementia unit at all times.	30
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Contractual requirements in relation to completion of assessments, risk assessments and risk assessment reviews and care plan reviews have not been adhered. Two rest home and two	Provide evidence that timeframes are adhered to in regards to completion of assessments, risk assessments, reviews of risk assessments and care plan evaluations.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>dementia resident files reviewed evidence that risk assessment reviews and care plan evaluations have been conducted 11 months after last review. These were completed in July 2014 – prior to this in August 2013.</p>		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA High			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA High	<p>a) Initial assessments have not been conducted on admission or are incomplete for four residents – one rest home and three dementia residents; b) Risk assessments (pain, nutrition, falls risk, pressure risk, continence or behaviours) have not been conducted for two rest home and one dementia residents; c) Falls risk and pressure area risk has been conducted for the following residents, however, other identified clinical risks have not been assessed including: one rest home</p>	Ensure all required assessments are completed for all identified care issues.	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				resident (no continence, nutrition or pain); one rest home (no continence, nutrition or behaviour); two dementia residents (no continence, nutrition, pain or behaviours); d) Challenging behaviour assessment (dementia respite resident) has not been completed for a resident displaying challenging behaviours including wandering.		
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA High			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA High	A)One respite resident, who was admitted on XXXXX, does not have an initial/short term care plan in place; b)There is no long term care plan in place for two residents – one rest home and one dementia. The rest home resident was admitted XXXXX and the dementia resident was admitted XXXX; c) Short term care plans for short term care issues are not recorded in sufficient	a)Ensure that all residents including respite residents have an initial care plan in place to guide care staff; b) Ensure that all permanent residents have a long term care plan in place to guide care staff in the safe and appropriate delivery of care and services; c) Ensure that all short term care issues have either a short term care plan in place or changes are made to the long term care plan and include	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				detail to guide care staff. Short term care plans reviewed included infections e.g. XXXX XXXX in use. No further information is recorded in relation to monitoring, or care interventions.	goals and interventions to guide staff in the safe and appropriate delivery of care and services.	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	Medications charts for three of six rest home and one of eight dementia residents are not signed by the prescriber Controlled drug order for one dementia resident on regular XXXXX is not recorded on the current medication chart. Advised that the charts are generated from the local pharmacy and this has been left off in error. The prescription for this medication is current. Advised that the pharmacist has been notified to make an amendment to this order. This will then	a)Ensure that all medication orders are signed by the prescriber; b) Ensure that all medications administered to residents have a corresponding order; c) Review standing orders annually as per medication guidelines; d) Cease transcribing of medication orders; e) Ensure that all staff with administration responsibilities follow correct administration procedures; f) Ensure that medication storage security is maintained at all times; g) Ensure that weekly checks of all controlled drugs are undertaken.	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>require signing by the GP.</p> <p>Standing orders are out of date- last reviewed on 3 July 2013.</p> <p>Transcribing of non-packaged and PRN medication orders has occurred on to a front sheet in each medication folder.</p> <p>This form has been generated to guide staff.</p> <p>One caregiver was observed during a lunch time medication round and was noted to have signed the medication administration sheet prior to administering the medications.</p> <p>Medication cupboards are locked and controlled drugs are stored securely in a locked box – one in each area of service.</p> <p>However, the keys to the cupboard and controlled drugs box were left unattended on the nurse's desk in the dementia unit during the audit.</p> <p>On review of the controlled drug register, it was noted that regular weekly controlled drug checks have not routinely</p>		

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				been conducted.		
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Medication competencies have not been conducted in the past 12 months and observation of practice is not recorded. The registered nurse does not have a current medication competency completed.	Ensure that all staff that have responsibilities for administering medications are assessed annually, including a documented observation of practice.	30
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.13.2	Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	One resident in the dementia unit requires assistance with her meals and drinks. The resident was observed to be fed her lunch time meal by another resident (rest home) who visits the dementia unit daily for socialisation. Staff (two) were noted to be in the dining room during meal service serving and assisting other residents. Improvement is required.	Ensure that all residents' nutritional needs are met and that residents are safely and appropriately assisted with their meals and drinks by care staff only.	30
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement,	PA Moderate	a) Food items (four) in one chest freezer	a) Ensure all food stored in the fridges	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		were noted not be covered and dated; b) Hot food is transported to the rest home and dementia dining rooms for serving. The service does not monitor if the food is kept hot during the serving of meals; c) The service only records hot food temperatures twice a month prior to leaving the kitchen.	and freezers is covered and dated; b) Provide a food service system that maintains hot food at the optimum temperature to ensure that food safety is not compromised; c) Conduct food temperature checks for each hot food dish prior to serving.	
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.1.1	Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Moderate	Cleaning chemicals were observed to be stored on the shelves of one toilet in the dementia unit and in the nurse's cupboard of the dementia unit which is not locked.	Ensure that all chemicals are stored safely and securely.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		facilities that are fit for their purpose.				
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Medical equipment including thermometers, blood pressure machines and sit on scales have not been calibrated and checked for accuracy.	Ensure that all medical equipment is calibrated by an authorised technician.	90
HDS(C)S.2008	Criterion 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.	PA Moderate	On a tour of the facility it was noted that in one communal bathroom in the rest home area has a portion of the floor covering that has lifted and bubbled creating a trip hazard.	Ensure that all hazards, such as uneven floor surfaces, are managed appropriately (minimise, isolate, eliminate) to provide a safe environment for residents and staff.	30
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low			
HDS(C)S.2008	Criterion 1.4.6.2	The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Low	On a tour of the facility it was noted that one resident room in the dementia unit has a strong urine odour from the floor covering. Advised that the service is aware of this issue and corrective actions are underway.	Ensure that the facility cleanliness and hygiene is maintained and that the service is free from odours.	60
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency,	Consumers receive an appropriate and timely	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	And Security Systems	response during emergency and security situations.				
HDS(C)S.2008	Criterion 1.4.7.4	Alternative energy and utility sources are available in the event of the main supplies failing.	PA Low	There is no gas bottle onsite for the BBQ.	Ensure that there is a gas bottle available for emergency use at all times.	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	The use of environmental restraint is not listed in restraint policy as an authorised form of restraint.	Conduct a review of restraint minimisation and safe practice policies and procedures to include environmental restraint.	90
HDS(RMSP)S.2008	Standard 2.2.1: Restraint approval and processes	Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.2.1.1	The responsibility for restraint process and approval is clearly	PA Moderate	a) One rest home resident (admitted in April 2014) has not	a) and b) Ensure that appropriate approval for all restraint is use	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		defined and there are clear lines of accountability for restraint use.		been assessed for the environmental restraint, has no completed authorisation and consent and has no long term care plan developed in which to include the environmental restraint; b) Environmental restraint is imposed on other rest home residents without their consent.	is obtained and documented prior to restraint use.	
HDS(RMSP)S.2008	Standard 2.2.2: Assessment	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.2.2.1	In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the	PA Moderate	One rest home resident with environmental restraint does not have assessment documentation completed for this type of restraint. The resident goes to the dementia unit every day and returns to the rest home unit in the evening for her evening meal and to sleep in her room.	Ensure all restraint use is appropriately assessed and documented prior to use.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>				
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.2.3.2	<p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last</p>	PA Low	<p>Advised that a resident from the rest home spends each day in the dementia unit. The resident goes there by choice and returns to the rest home area for the evening meal and to sleep in her room. There is no record of this type of restraint being used in the resident's file. No long term care plan</p>	Where restraint is in use, ensure that this is recorded as part of the care planning process.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>		has been developed (link #1.3.5.2).		
HDS(IPC)S.2008	Standard 3.1: Infection control management	There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low			
HDS(IPC)S.2008	Criterion 3.1.9	Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.	PA Low	(i) There are no disposable hand towels available in a toilet area in the Dementia unit (the service uses cloth towels). (ii) There are uncovered supplies of towels stored in the bathrooms for use following showers which do not meet best practice for	(i) and (ii) Ensure that there are supplies of disposable hand towels and ensure that towels are not stored in bathrooms uncovered.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				infection prevention and control measures.		
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low			
HDS(IPC)S.2008	Criterion 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.	PA Low	(i) Monthly infection data is collected for infections that are treated with antibiotics only. (ii) Infections are recorded on short term care plans however there is no evidence that signs and symptoms of infection, treatment, follow up, and resolution are completed as evidenced in two short term care plans sighted for March and April 2014.	(i) Ensure that all infections based on signs and symptoms of infection are recorded. (ii) Ensure that all infections have documented signs and symptoms, treatment, follow up and resolution completed.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

A Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (four caregivers, one diversional therapist, one nurse manager and one enrolled nurse) confirm their familiarity with the Code. Interviews with five residents and six relatives (two rest home and four dementia) confirm the services being provided are in line with the Code of rights. Code of rights/advocacy/complaints training is a mandatory requirement and is provided during orientation, however training as part of the education programme for staff has not been provided in the last two years (# link 1.2.7.5).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with five residents and six relatives (two rest home and four dementia) identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Resident/relative meetings (last meeting minutes sighted for January 2014) are held providing the opportunity to raise concerns in a group setting, however these meetings have not been held three monthly according to the meeting schedule (# link 1.2.3.5). The most recent annual satisfaction survey (January 2014) has not yet been collated, analysed and results reported back to residents, relative and staff (# link 1.2.3.5). The annual satisfaction survey results for 2013 could not be located on the day of the audit. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner Information.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity (# link 1.2.3.4). Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. There is one toilet in the dementia unit that does not have a door, only a curtain, and one toilet in the rest home that does not have a lock or a sign to indicate the toilet is being used. Resident's privacy in these areas is not maintained. This is an area requiring improvement.

Discussions with five residents and six relatives (two rest home and four dementia) confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.

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

D14.4 there are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents' file

Church services are held monthly. Contact details of spiritual/religious advisors are available to staff. All five residents and six relatives (two rest home and four dementia) confirm the service is respectful.

A resident satisfaction survey is scheduled to be carried out annually to gain feedback however the 2013 survey could not be located and the results of the 2014 survey distributed in January 2014 has not yet been collated or analysed (# link 1.2.3.6).

D4.1a: Residents' files include their cultural and /or spiritual values when identified by the resident and/or family.

The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with five residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Seven care plans (three rest home and four dementia) reviewed identify specific individual likes and dislikes.

The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect is a mandatory requirement and was provided in April 2014. Discussions with the nurse manager and four caregivers report there have been no identified incidents of abuse or neglect.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity (# link 1.2.3.4). Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.

**Finding:**

There is one toilet in the dementia unit that does not have a door only a curtain and one toilet in the rest home that does not have a lock or a sign to indicate the toilet is being used.

**Corrective Action:**

Ensure there are doors on all toilets with locks or signs to indicate in use or vacant to maintain privacy of residents.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. There were no Maori residents living at the facility at the time of the audit. There is information and websites provided within the Maori health plan to provide quick reference

and links with local Maori healthcare providers.

D20.1: The service utilises a local Maori consultant on an as-needed basis for consultation. This individual is identified in policy.

Interviews with four caregivers and one nurse manager confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau (# link1.2.3.3).

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

The organisation plans to ensure Māori receive services commensurate with their needs.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Care planning includes consideration of spiritual, psychological and social needs. Five residents indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Six relatives (two rest home and four dementia) report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions however resident/relative meetings have not been conducted according to the meeting schedule (# link 1.2.3.5)

D3.1g: The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse (# link 1.3.5.2).

D4.1c: Four care plans (three rest home and one dementia) reviewed include the residents' social, spiritual, cultural and recreational needs (# link 1.3.5.2).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)**

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with four caregivers, one nurse manager and one enrolled nurse acknowledge their understanding of professional boundaries.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility (# link 1.2.3.1), (# link 1.2.3.3), (# link 1.2.3.5), (# link 1.2.3.6). Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The nurse manager is in charge of the internal audit and in-service education programmes. There is access to computer and Internet resources. There are scheduled monthly staff meetings and three monthly resident meetings (# link 1.2.3.5).

Five residents and six relatives (two rest home and four dementia) interviewed spoke very positively about the care and support provided. Four caregivers, one enrolled nurse, one diversional therapist and the nurse manager have a sound understanding of principles of aged care.

A2.2: Services are provided at Ashlea Grove rest home that adheres to the Health & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring which requires improvements (# link 1.2.3.6).

D17.7c: There are implemented competencies for caregivers and registered nurses with exceptions (# link 1.3.12.3). There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

### Evidence:

Policies are in place relating to open disclosure. Five residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.

A sample of eleven incident reports reviewed, and associated resident files, evidences recording of family notification in two of the files reviewed however six relatives (two rest home and four dementia) interviewed confirm they are notified of any changes in their family member's health status. This is an area requiring improvement. The nurse manager can identify the processes that are in place to support family being kept informed.

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 for that are not covered by the agreement.

The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.

D11.3 The information pack is available in large print and is read to sight-impaired residents.

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

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

**Attainment and Risk:** PA Low

### Evidence:

Policies are in place relating to open disclosure. Five residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.

A sample of incident reports reviewed, and associated resident files, evidence recording of family notification in two of 11 files reviewed however six relatives (two rest home and four dementia) interviewed confirm they are notified of any changes in their family member's health status. The nurse manager can identify the processes that are in place to support family being kept informed.

### Finding:

In the sample of incident reports reviewed and on review of six resident files, there is a lack of documented evidence that family are informed of residents' incidents, accidents in nine of 11 files reviewed.

### Corrective Action:

Provide clear evidence that family are communicated with following incidents, accidents.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Ashlea Grove rest home has policies and procedures relating to informed consent and advanced directives. A review of seven files (three rest home, four dementia) identified that five of seven files included informed consent collected for photos, health information and outings as part of the admission process and agreement. Two residents – one rest home and one dementia resident files did not include signed consent forms. Improvements are required in this area.

There is an advanced directive form and process. Seven resident files evidenced that these forms were completed appropriately. Where the resident is unable or unwilling to make a decision regarding advanced directives and resuscitation, then the resident is by default for resuscitation. Enduring power of attorney for care and welfare are activated for four dementia and one rest home resident.

There were six admission agreements sighted which were signed by the resident or nominated representative. The seventh file was a respite resident.

Discussion with six family (two rest home and four dementia) identified that the service actively involves them in decisions that affect their relatives' lives.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

The service is able to demonstrate that written consent is obtained where required.

**Attainment and Risk:** PA Low

**Evidence:**

A review of seven files (three rest home, four dementia) identified that five of seven files included informed consent collected for photos, health information and outings as part of the admission process and agreement.

**Finding:**

There was no informed consent form signed for one rest home resident and one dementia resident.

**Corrective Action:**

Obtain written documentation in relation to informed consent for all residents.

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

**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

.

**Corrective Action:**

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

### **Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)**

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

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

**Attainment and Risk:** FA

**Evidence:**

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.

Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items (# link 1.2.3.5).

D4.1e; The residents' files include information on residents family/whānau and chosen social networks.

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussions with six relatives (two rest home and four dementia) identify that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The client information pack informs visiting can occur at any reasonable time. Interviews with five residents and six relatives (two rest home and four dementia) confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.

D3.1.e Discussions with five residents and six relatives (two rest home and four dementia) verify that they are supported and encouraged to remain involved in the

community. Ashlea Grove rest home supports on-going access to community services (e.g. church, general practitioner visits, and family outings). Entertainers are invited to perform at the facility.

D3.1h: Discussions with six families verify that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are supported to access services within the community when appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.

Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service.

Interviews with five residents and six relatives (two rest home and four dementia) are familiar with the complaints procedure and state any concerns or complaints are addressed.

The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved.

There have been no complaints in the last two years. There have been two documented verbal complaints in January 2012 and April 2012. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint.

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

E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

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

#### **Criterion 1.1.13.1 (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:**

Ashlea Grove Rest Home provides rest home level care for up to 37 residents in a 15 bed dementia unit and a 22 bed rest home wing. Occupancy on the day of the audit included 15 residents in the dementia unit and 11 rest home residents (including one rest home respite). A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home. The dementia unit now includes 15 residents. The mission statement sets out the vision and values of the service: "To provide all our residents with a safe, caring and supportive environment that is comfortable, homely and enables residents to maintain their independence as much as possible regardless of race or creed. The mission statement is included in the information booklet, which is given to each resident and family on admission.

An organisational chart visually describes reporting relationships for the management structure. The service has a draft business and quality plan for 2014/2016 which has a vision, mission and philosophy (# link 1.2.3.1). This plan lists goals which relate to maintaining occupancy, implementing the quality programme, managing business risks, governance, achieving successful audit outcomes, to drive continuing improvement and to maintain standards and meet the conditions of certification. The internal audit programme assesses service performance (# link 1.2.3.6).

The business is owned by Elsdon Enterprises Limited who is directly responsible for all financial matters including dealing directly with staff for wages. The nurse manager is in contact with the owners via e-mail and phone contact. The nurse manager has been at the service since October 2012 (employed as a registered nurse) and has been in the role of the nurse manager since Feb 2014. The nurse manager has worked in aged care since 2004 when she qualified as a registered nurse and has an understanding of aged care. The nurse manager has maintained at least eight hours of professional development which includes the following: attended a wound care study day in 2013, a

registered nurse clinical study day in June 2014, an aged care association manager's day July 2014 (focus on audits and MOH reporting requirements), InterRAI training, attends DHB aged care managers meeting three monthly and is a member of NZNO Otago gerontology committee.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

.

**Finding:**

.

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the nurse manager's absence, a casual registered nurse known to the service is in charge (# link 1.2.8.1). The nurse manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the owner.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is a draft quality and business plan (2014-2016) to be implemented by the manager and owner.

A set of policies and procedures are in place. Not all policies have been reviewed and updated two yearly as documented in the policy review policy. The service does not have a policy on skin management and the self-medicating policy does not state that a resident requires a three monthly competency check. These are areas requiring improvement. The service has employed an external consultant to assist the nurse manager with policy review. The nurse manager signs off on all new policies. Reviewed

policies are available for staff to read and to sign after reading as sighted. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. There is a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.

Key components of service delivery are linked to the quality and risk management programmes. The service has a draft business and quality plan for 2014/2016 (to be signed off by the owners). This is an area requiring improvement. This plan lists goals which relate to maintaining occupancy (especially in the dementia unit), implementing the quality programme, managing business risks, maintenance and repairs, growing the activities programme and achieving successful audit outcomes. The business and quality plan vision statement "we believe we have a duty to provide a nurturing supportive environment giving residents on-going assistance to achieve what they want to achieve in their daily lives". The service mission statement "we believe in quality of life with dignity and respect. To provide a safe, caring environment for residents of all ages and lifestyles, including their whanau and our staff. Our team of competent staff is committed to working in partnership with residents to achieve their on-going independence- supporting their right to being an individual". The quality philosophy states "we are committed to implementing on-going quality improvement via a business quality plan which is simple, relevant, and achievable and resident focused. We believe the plan should result in on-going improvement on the resident's home environment, service and holistic care along with improvement in home's system and routines. Above all we are committed to maintaining a homelike environment for the residents where quality, comfort and care go hand in hand".

The internal audit programme assesses service performance. The resident/relative survey conducted in January 2014 has yet to be collated and analysed. The annual satisfaction survey for 2013 could not be located during the audit and therefore results unable to be sighted. This is an area requiring improvement. The nurse manager reports that results from January 2014 overall appear positive (seven respondents). Residents/families were surveyed around privacy and respect, medical services, assistance from care staff, cleaning, food services, activities, laundry, safety and security and the environment. Residents meetings are scheduled to be held three monthly. A residents meeting was held in September 2013 and January 2014. There have been no meetings since January 2014. Staff meetings are scheduled to be three monthly with standing agenda items including incident and accident reporting, infection control, complaints and compliments, health and safety, internal audits and in-service education. Staff meetings held as sighted in November 2013, April 2014 and July 2014. Management meetings are scheduled to be held three monthly. The last management meeting was held in November 2013 (upgrades on bathroom and policy manual updates was documented as being discussed). Improvements are required in these areas.

The internal audit programme involves monitoring areas of quality and risk including event reporting, complaints management, infection prevention and control, health and safety, and restraint minimisation. A process to measure achievement against the quality and risk management plan is in place. The nurse manager is responsible for ensuring all internal audits are completed. An internal audit schedule includes care plan audits (six monthly), medication (six monthly), cleaning (six monthly), laundry (annually), activities programme, food service (six monthly) and the restraint minimisation programme (annually). However, on review of the completed audits for 2013 year-to-date, it is noted that not all audits have been complete as per the audit schedule. Scheduled audits not completed include care planning (February 2014), complaints (March 2014), environment and equipment (March 2014), restraint (March 2014), continence (April 2014), medication (April 2014), privacy and safety (April 2014), cultural and spiritual (May 2014), infection (May 2014) and admissions (June 2014). This is an area requiring improvement.

Data that is collected is analysed, evaluated and communicated to staff where completed. Corrective actions are put into place when opportunities for improvements are identified. Results of the internal audits are discussed in the three monthly staff meetings and management meetings however these meetings have not been held as per the meeting schedule.

The nurse manager oversees all quality initiatives with support from the owner.

Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. There is no evidence that the hazard register is updated as new hazards are identified. This is an area requiring improvement.

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.

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

D19.2g: Falls prevention strategies include sensor mats and closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercise and walking groups.

### 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):** 30 (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:** PA Moderate

**Evidence:**

A comprehensive set of policies and procedures are in place. The service has employed a casual registered nurse (RN) to assist the nurse manager with policy review. The nurse manager signs off on all new policies. Reviewed policies are available for staff to read and to sign after reading as sighted. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. As a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.

**Finding:**

(i) Not all policies have been reviewed and updated two yearly as documented in the policy review policy. (ii) The service does not have a policy on skin management and the self-medicating policy does not state that a resident requires a three monthly competency check.

**Corrective Action:**

(i) Ensure that all policies are reviewed two yearly. (ii) Ensure that the service has a policy on skin management and that the policy on self-medication is updated to included competency reviews three monthly as per the medicines care guide for residential aged care.

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

#### **Criterion 1.2.3.4 (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:** PA Moderate

**Evidence:**

Key components of service delivery are linked to the quality and risk management programmes. The service has a draft business and quality plan for 2014/2016 (to be signed off by the owners). This plan lists goals which relate to maintaining occupancy (especially in the dementia unit), implementing the quality programme, managing business risks, maintenance and repairs, growing the activities programme and achieving successful audit outcomes. The internal audit programme regularly assesses service performance. The resident/relative survey conducted in January 2014 has yet to be collated and analysed. The annual satisfaction survey for 2013 could not be located during the audit and therefore results unable to be sighted. This is an area requiring improvement. The nurse manager reports that results from January 2014 overall appear positive (seven respondents). Residents/families were surveyed around privacy and respect, medical services, assistance from care staff, cleaning, food services, activities, laundry, safety and security and the environment. Residents meetings are scheduled to be held three monthly. A residents meeting was held in September 2013 and January 2014. Staff meetings are scheduled to be three monthly with standing agenda items including incident and accident reporting, infection control, complaints and compliments, health and safety, internal audits and in-service education. Staff meetings held as sighted in November 2013, April 2014 and July 2014. Management meetings are scheduled to be held three monthly. The last management meeting was held in November 2013 (upgrades on bathroom and policy manual updates was documented as being discussed).

**Finding:**

(i) The annual satisfaction survey for 2013 could not be located during the audit and therefore results unable to be sighted. (ii) There have been no residents meetings since January 2014. (iii) Staff meetings have not been held three monthly as scheduled. (iv) Management meetings have not been held three monthly as scheduled; (v) The business and quality plan for 2014/2016 is in draft form only.

**Corrective Action:**

(i) Ensure that satisfaction surveys are collated and analysed and results reported. (ii), (iii) and (iv) Ensure that meetings are held as scheduled; (v) Ensure that the business and quality plan is signed off and implemented

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

**Criterion 1.2.3.6 (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 Low

**Evidence:**

The internal audit programme involves monitoring areas of quality and risk including event reporting, complaints management, infection prevention and control, health and safety, and restraint minimisation. Various aspects of the service are regularly monitored with examples including , care plan audits (six monthly), medication (six monthly), cleaning (six monthly), laundry (annually), activities programme, food service (six monthly) and the restraint minimisation programme (annually). A process to measure achievement against the quality and risk management plan is in place. The nurse manager is responsible for ensuring all internal audits are completed

**Finding:**

On review of the completed audits for 2013 year-to-date, it is noted that not all audits have been complete as per the audit schedule. Scheduled audits not completed include care planning (February 2014), complaints (March 2014), environment and equipment (March2014), restraint (March 2014), continence (April 2014), medication (April 2014), privacy and safety (April 2014), cultural and spiritual (May 2014), infection (May 2014) and admissions (June 2014).

**Corrective Action:**

Ensure that all audits are completed as per the audit schedule.

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

**Criterion 1.2.3.7 (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:** PA Low

**Evidence:**

Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register.

**Finding:**

There is no evidence that the hazard register is updated as new hazards are identified

**Corrective Action:**

Ensure all new hazards are entered onto the hazard register when identified.

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

**Evidence:**

D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Adverse events (including but not limited to: falls, skin tears, infections, medicine errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by the nurse manager. Incident forms sampled for July 2014 (11) related to nine residents and included one resident with three falls, six residents with falls, one resident with a skin tear and one resident with a medication error. Family interviewed advised that they are informed of any adverse event relating to their relative however this is not evident in eight of the incident forms reviewed and two of the residents progress notes reviewed (# link 1.9.1.1). There is no documented evidence that the nurse manager has reviewed two residents following a falls incident. Caregivers provide first aid and assistance to the resident and the nurse manager is available for on-call advice if required (nurse manager lives 40 minutes away). The nurse manager is on call during the week and the caregiver is on call over the weekend (# link 1.2.8.1). Advised that the nurse manager investigates the event, and records further follow up and recommendations if required. One resident with XXXXXX (dementia) has not had this reported via the incident reporting system. All 11 forms reviewed were complete with further investigations and sign off recorded by the nurse manager. Improvements are required in this area. Monthly incident/accident analysis is conducted and results discussed at staff meetings (# link 1.2.3.5).

Advised by the nurse manager that statutory and regulatory obligations are understood, however, five residents living at Ashlea Grove were observed on the days of audit as requiring different levels of care than what they have been assessed as, and there is no evidence of notification to HealthCERT or the DHB. Improvements are required in this area. The nurse manager was able to give examples of instances of notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.

There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

### Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

**Attainment and Risk:** PA High

**Evidence:**

The nurse manager was able to give examples of instances of notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner. Advised by the nurse manager that statutory and regulatory obligations are understood, however, five residents living at Ashlea Grove were observed on the days of audit as requiring different levels of care than what they have been reassessed as, and there is no evidence of notification to HealthCERT or the DHB.

**Finding:**

- a) One resident in the rest home area was observed as hospital level care.

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

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

c) One respite resident residing in the rest home

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

d) One resident living in the rest home

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

**Corrective Action:**

Ensure that essential reporting is conducted and that relevant authorities are notified of changes in the care levels of residents residing at Ashlea Grove rest home including DHB and HealthCERT. The service is required to ensure that all residents receive care and services appropriate to their assessed needs.

**Timeframe (days):** 7 (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:** PA Moderate

**Evidence:**

Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by the nurse manager. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted). There is an accidents and incidents policy, preventing and management of falls policy and monthly incident and accident analysis.

Incident forms sampled for July 2014 (11) related to nine residents and included one resident with three falls, six residents with falls, one resident with a skin tear and one resident with a medication error. Family interviewed advised that they are informed of any adverse event relating to their relative however this is not evident in eight of the incident forms reviewed and two of the residents progress notes reviewed (# link 1.9.1.1).

**Finding:**

There is no documented evidence that the registered nurse manager has reviewed two residents following a falls incident.

**Corrective Action:**

Ensure that the registered nurse manager reviews all residents following incidents and that this is documented.

**Timeframe (days):** 60 (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 Moderate

### **Evidence:**

There are 22 staff employed by Ashlea Grove Rest Home which includes a nurse manager, enrolled nurse, caregivers, and kitchen staff and a diversional therapist. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the nurse manager. Practising certificates were also sighted for general practitioners.

Seven staff files were randomly selected for review (one nurse manager, one enrolled nurse, three caregivers, one cook and one diversional therapist). Five from seven staff files reviewed have evidence of signed job descriptions. This is an area requiring improvement. Five from seven staff files reviewed show evidence of reference checks completed. This is an area requiring improvement. Ashlea Grove has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for two caregivers). Interviews with two recently employed caregivers confirm their orientation to the service was thorough. Five from seven staff files reviewed reflected evidence of an orientation programme that had been completed. This is an area requiring improvement. Four staff files reviewed showed evidence of performance appraisals however historically performance appraisals in these four files have not been completed annually (three staff files have not been at the service longer than one year). This is an area requiring improvement.

There is a completed in-service calendar for 2013 and a plan in place for 2014. The annual training programme exceeds eight hours annually.

Caregivers have completed either the national certificate in care of the elderly or are working towards completion. All care givers are expected to complete the dementia unit standards – with 12 of 16 caregiving staff having completed the dementia standards within the appropriate timeframe. This is an area requiring improvement. Caregivers work across both rest home and dementia service levels at Ashlea Grove. The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

A system is in place to identify, plan, facilitate and record on-going education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. The education and training plan for 2013 included the following: fire and evacuation, urinary tract infections, medication, outbreak management, civil defence and emergencies, confidentiality, wound care death, dying and dignity cultural awareness and documentation. Education provided in 2014 has included resident cares (February), abuse and neglect (April), Parkinson's (June) and fire drill (July). Training for code of rights, continence, manual handling, hoist use and chemical safety has not been provided in the last two years. Fire drills have not been conducted six monthly. This is an area requiring improvement. Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions. The nurse manager has attended InterRAI training.

Registered nurse and caregiver competencies include medication knowledge however there is no documented observation of medication administration (# link 1.3.12.3).

Ashlea Grove has an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5f There are 16 caregivers working in the dementia unit, 12 have completed the required dementia standards, four caregivers are in the process of completing the required standards and all four have been employed for more than 12 months. This is an area requiring improvement.

**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:** PA Low

**Evidence:**

There are 22 staff employed by Ashlea Grove which includes a nurse manager, enrolled nurse, caregivers, and kitchen staff and activities person. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the nurse manager. Practising certificates were also sighted for general practitioners.

Seven staff files were randomly selected for review (one nurse manager, one enrolled nurse, three caregivers, one cook and one diversional therapist). Five from seven staff files reviewed have evidence of signed job descriptions. Five from seven staff files reviewed show evidence of reference checks completed. Five from seven staff files reviewed reflected evidence of an orientation programme that had been completed

**Finding:**

(i) Two of seven staff files do not show evidence of signed job descriptions. (ii) Two of seven staff files do not show evidence of reference checks. (iii) Four staff files do not show evidence that performance reviews have been conducted annually.

**Corrective Action:**

(i) Ensure that all staff have signed job descriptions. (ii) Ensure that all staff have reference checks completed prior to employment. (iii) Ensure that performance reviews are completed annually.

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

**Evidence:**

Ashlea Grove has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for two caregivers). Interviews with two recently employed caregivers confirm their orientation to the service was thorough. Five from seven staff files reviewed reflected evidence of an orientation programme that had been completed

**Finding:**

Two from seven staff files reviewed do not show evidence that an orientation programme has been completed.

**Corrective Action:**

Ensure that all staff complete an orientation programme.

**Timeframe (days):** 90 (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 Moderate

**Evidence:**

A system is in place to identify, plan, facilitate and record on-going education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. The education and training plan for 2013 included the following: fire and evacuation, urinary tract infections, medication, outbreak management, civil defence and emergencies, confidentiality, wound care death, dying and dignity cultural awareness and documentation. Education provided in 2014 has included resident cares (February), abuse and neglect (April), Parkinson's (June) and fire drill (July). Caregivers have completed either the national certificate in care of the elderly or are working towards completion. All caregivers are expected to complete the dementia unit standards – 12 of sixteen caregivers have completed dementia standards

**Finding:**

(i) Training for code of rights, continence, manual handling, hoist use and chemical safety has not been provided in the last two years. (ii) Fire drills have not been conducted six monthly. (iii) Four of sixteen caregivers have not completed dementia standards within the appropriate time frame.

**Corrective Action:**

(i) and (ii) Ensure that required training is conducted within the appropriate time frame and that fire drills are conducted six monthly. (iii) Ensure that staff completed dementia standards within the appropriate time frame.

**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:** PA Moderate

### Evidence:

A good employer policy is in place which includes staffing levels and skills mix. Staffing rosters were sighted. Part time staff fill casual shifts and no agency staff are available. The nurse manager works fulltime. The service has just employed an enrolled nurse to work 24 hours per week. The nurse manager is available on call after hours Sunday-Thursday evening. There is a senior caregiver on call Friday and Saturday who makes clinical decisions. This is an area requiring improvement. There is further support from general practitioner and St Johns ambulance service if required. Care staff interviewed advised that they are well supported by the nurse manager. Roster includes four caregivers on the morning shift (two in the dementia unit and two in the rest home), and four on in the afternoon (two in the dementia unit and two in the rest home) and two overnight (one in the dementia unit and one in the rest home). The caregiver from the dementia unit leaves the unit at night to assist the rest home caregiver attend to a resident in the rest home who requires two person assist to turn the resident (# link1.2.4.2). The caregiver from the dementia unit is also required to respond to calls from the eight cottages owned by the council. In both these situation the dementia unit is left unattended. This is an area requiring improvement. A cook and a kitchen hand are employed during the day. Activities are provided from 1.30-2.30pm in the rest home and 3.00pm-5.00pm in the dementia unit by a diversional therapist. Staff turnover is reported by the owner as low.

One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.

Five residents and six relatives (two rest home and four dementia) confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

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

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

**Attainment and Risk:** PA Moderate

### Evidence:

A good employer policy is in place which includes staffing levels and skills mix. Staffing rosters were sighted. Part time staff fill casual shifts and no agency staff are available. The nurse manager works fulltime. The service has just employed an enrolled nurse to work 24 hours per week. The nurse manager is available on call after hours Sunday-Thursday evening. Care staff interviewed advised that they are well supported by the nurse manager. Roster includes four caregivers on the morning shift (two in the dementia unit and two in the rest home), and four on in the afternoon (two in the dementia unit and two in the rest home) and two overnight (one in the dementia unit and one in the rest home)

### Finding:

(i) There is a senior caregiver on call Friday and Saturday who makes clinical decisions. (ii) The caregiver from the dementia unit leaves the unit at night to assist the rest home caregiver attend to a resident in the rest home who requires two person assist to turn the resident (# link 1.2.4.2). (iii) A caregiver, usually from the rest home, is also required to respond to calls from the eight cottages owned by the council. In ii) the dementia unit is left unattended while iii) would see the rest home left unattended..

### Corrective Action:

(i) Ensure that there is access to a registered nurse on call at all times for clinical decisions. (ii) and (iii) Ensure that there is enough staff on duty to maintain a staff presence in the dementia unit at all times.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:** The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record (# link 1.3.4.2) An initial care plan is also developed in this time (# link 1.3.5.2). Residents' files are protected from unauthorised access by being locked away in the nurse's station. Informed consent to display photographs is obtained from residents/family/whanau on admission (# link 1.1.10.4). Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Six family members (two rest home and four dementia) and five rest home residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for six of seven resident files sampled (one respite). The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

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

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

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a policy and process that describe resident's admission and assessment procedures. The nurse manager (registered nurse) undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission for two rest home residents (link findings #1.3.4.2, 1.3.5.2). The long term care plan is developed within three weeks of admission for two rest home and two dementia resident files reviewed (link

finding #1.3.5.2). The completed initial assessments, initial care plans and long term care plans completed are signed off by the nurse manager. Reviews are conducted six monthly or earlier if resident health changes, and are completed by the nurse manager for one rest home and one dementia resident. Improvements are required in this area in relation to time frames for completion of evaluations and review of risk assessments. Those residents, who have had reviews completed, have been done so with input from the care staff, the diversional therapist and any other relevant person. Activities assessments, social profiles, interests and diversional therapy plans are developed by the diversional therapist. Handover occurs at the end of each duty that maintains a continuity of service delivery. There is a handover folder and staff information folder including memos and reviewed policies, which staff read. The nurse manager and a senior caregiver share on-call and after hours and weekends cover (link finding #1.2.8.1)

Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of six of seven resident files sampled (one respite). It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. On interview, the GP advised that she conducts three monthly clinical and medication reviews, and that the nurse manager contacts her in a timely fashion, providing her with information required to assess the residents. The service carries out any observations and interventions she prescribes.

There is a range of assessment tools available for completion on admission and to be reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment and f) behaviours. It is noted that risk assessments have not been conducted for all identified resident care issues (link finding #1.3.4.2). Advised by the nurse manager that she has commenced using the InterRAI assessment tool, however, this was not evident in the seven files reviewed. Long term care plans reviewed for two rest home and two dementia residents' evidence comprehensive and resident focused goals and interventions (link finding #1.3.5.2). All seven files identified integration of allied health including podiatry.

Tracer Methodology:

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a policy and process that describe resident's admission and assessment procedures. The nurse manager (registered nurse) undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission for two rest home residents (link findings #1.3.4.2, 1.3.5.2). The long term care plan is developed within three weeks of admission for two rest home and two dementia resident files reviewed (link finding #1.3.5.2). The completed initial assessments, initial care plans and long term care plans are signed off by the nurse manager. Reviews are conducted six monthly or earlier if resident health changes, and are completed by the nurse manager for one rest home and one dementia resident. Those residents, who have had reviews completed, have been done so with input from the care staff, the diversional therapist and any other relevant person. Activities assessments, social profiles, interests and diversional therapy plans are developed by the diversional therapist.

There is a policy and process that describe resident's admission and assessment procedures. The nurse manager (registered nurse) undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission for two rest home residents (link findings #1.3.4.2, 1.3.5.2). The long term care plan is developed within three weeks of admission for two rest home and two dementia resident files reviewed (link finding #1.3.5.2). The completed initial assessments, initial care plans and long term care plans are signed off by the nurse manager. Reviews are conducted six monthly or earlier if resident health changes, and are completed by the nurse manager for one rest home and one dementia resident. Those residents, who have had reviews completed, have been done so with input from the care staff, the diversional therapist and any other relevant person. Activities assessments, social profiles, interests and diversional therapy plans are developed by the diversional therapist.

**Finding:**

Contractual requirements in relation to completion of assessments, risk assessments and risk assessment reviews and care plan reviews have not been adhered. Two rest home and two dementia resident files reviewed evidence that risk assessment reviews and care plan evaluations have been conducted 11 months after last review. These were completed in July 2014 – prior to this in August 2013.

**Corrective Action:**

Provide evidence that timeframes are adhered to in regards to completion of assessments, risk assessments, reviews of risk assessments and care plan evaluations.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA High

**Evidence:**

An initial nursing assessment is completed within 24 hours of admission for three of seven resident files reviewed – two rest home and one dementia residents. Four residents have not had an initial assessment conducted. Improvements are required in this area. The initial assessment document includes: hygiene and grooming, sensory and oral care, continence, diet, medication, mobility, skin integrity, pain, cognition and mood, sleep and routines, social, cultural, spiritual, and advance care planning. There are risk assessment tools available for use including continence, nutrition, pain, falls, pressure risk and behaviours. No risk assessments have been completed for three residents – two dementia and one rest home. Falls risk and pressure area risk assessments have been completed for four of seven residents – two rest home and two dementia but further assessments have not been conducted for other identified care issues. Improvements are required in this area. The InterRAI assessment tool has been commenced; however, no files reviewed included the InterRAI assessment tool. Assessments conducted are done so in an appropriate and private manner. The assessment tools, where completed, link to the individual care plans. The care plans, where completed (link #1.3.5.2), are individualised for the resident needs such as (but not limited to): hygiene and grooming, skin integrity, mobility, continence, nutrition, diabetes, sleep, medication, pain, orientation and perception, and social functioning. Each aspect of the completed care plan includes goals, interventions and assistance required and evaluations (link finding #1.3.3.3).

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

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

**Attainment and Risk:** PA High

**Evidence:**

An initial nursing assessment is completed within 24 hours of admission for three of seven resident files reviewed – two rest home and one dementia resident. The initial assessment document includes: hygiene and grooming, sensory and oral care, continence, diet, medication, mobility, skin integrity, pain, cognition and mood, sleep and routines, social, cultural, spiritual, and advance care planning. There are risk assessment tools available for use including continence, nutrition, pain, falls, pressure risk and behaviours. Falls risk and pressure area risk assessments have been completed for four of seven residents – two rest home and two dementia. The InterRAI assessment tool has been commenced; however, no files reviewed included the InterRAI assessment tool. Assessments conducted are done so in an appropriate and private manner. The assessment tools, where completed, link to the individual care plans.

**Finding:**

a) Initial assessments have not been conducted on admission or are incomplete for four residents – one rest home and three dementia residents; b) Risk assessments (pain, nutrition, falls risk, pressure risk, continence or behaviours) have not been conducted for two rest home and one dementia residents; c) Falls risk and pressure area risk has been conducted for the following residents, however, other identified clinical risks have not been assessed including: one rest home resident (no continence, nutrition or pain); one rest home (no continence, nutrition or behaviour); two dementia residents (no continence, nutrition, pain or behaviours); d) Challenging behaviour assessment (dementia respite resident) has not been completed for a resident displaying challenging behaviours including wandering.

**Corrective Action:**

Ensure all required assessments are completed for all identified care issues.

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

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

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

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

**Attainment and Risk:** PA High

**Evidence:**

Residents' files include; resident information and family contact sheet, initial nursing assessment (where completed), initial care plan (where completed), daily progress notes, observations chart, long term care plans, risk assessments (where completed), GP medical notes, lab results, allied health reports, activities, consents, advance directives, letters, discharge summaries, and NASC assessment.

The initial care plan is developed from the initial assessment (where completed) and identifies the areas of concern or risk, however, no initial care plan has been developed for one respite resident (dementia resident accommodated in the rest home). Improvement is required in this area. Long term care plans are individually developed with the resident and family/whanau. Four residents and five family members (three rest home and two dementia) interviewed stated they are involved in the care planning process. The care plans are individualised for each resident need such as (but not limited to): hygiene and grooming, skin integrity, mobility, continence, nutrition, diabetes, sleep, medication, pain, orientation and perception, and social functioning. Long term care plans are developed for five of four of six permanent residents. Improvements are required in this area. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.

There is evidence that residents are seen by the GP at least three monthly.

Short term care plans are available but have only been used to record an infection and the type of antibiotics in use. Improvements are required in this area.

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

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

**Attainment and Risk:** PA High

**Evidence:**

The initial care plan is developed from the initial assessment (where completed) and identifies the areas of concern or risk as evidenced in six permanent resident files reviewed. Long term care plans are individually developed with the resident and family/whanau. Five residents and six family members (two rest home and four dementia)

interviewed stated they are involved in the care planning process. The care plans are individualised for each resident need such as (but not limited to): hygiene and grooming, skin integrity, mobility, continence, nutrition, diabetes, sleep, medication, pain, orientation and perception, and social functioning. Long term care plans are developed for four of six permanent residents. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.

There is evidence that residents are seen by the GP at least three monthly.

Short term care plans are available but have only been used to record an infection and the type of antibiotics in use.

**Finding:**

A) One respite resident, who was admitted XXXXX, does not have an initial/short term care plan in place; b) There is no long term care plan in place for two residents – one rest home and one dementia. The rest home resident was admitted XXXXX and the dementia resident was admitted XXXXX; c) Short term care plans for short term care issues are not recorded in sufficient detail to guide care staff. Short term care plans reviewed included infections e.g. urinary tract infection and antibiotics in use. No further information is recorded in relation to monitoring, or care interventions.

**Corrective Action:**

a) Ensure that all residents including respite residents have an initial care plan in place to guide care staff; b) Ensure that all permanent residents have a long term care plan in place to guide care staff in the safe and appropriate delivery of care and services; c) Ensure that all short term care issues have either a short term care plan in place or changes are made to the long term care plan and include goals and interventions to guide staff in the safe and appropriate delivery of care and services.

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

### **Evidence:**

Ashlea Grove provides services for residents requiring rest home and dementia rest home level of care. Individualized care plans are completed for four permanent residents. One dementia respite resident and two permanent residents (one rest home and one dementia) do not have a long term care plan in place (link finding #1.3.5.2). The four caregivers and nurse manager interviewed stated that they have all the equipment referred to in long term care plans necessary to provide care, including sling hoist, wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.

Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment (link finding #1.4.2.1). There are currently three residents with wounds – one rest home and two dementia residents. These wounds include two residents with chronic diabetic leg ulcers and one resident with reoccurring cellulitis of both legs which the service is monitoring. Wound assessments and management plans are completed for all three residents' wounds and there was evidence of referral to wound and vascular specialists. There is one resident in the dementia unit who was receiving end of life care (link finding #1.2.4.2) who has developed a sacral pressure injury. Progress notes refer to pressure area cares provided, the progress of the injury and the long term care plan evidences skin care and pressure area care including wound dressings. The resident was nursed on a spenco mattress and was receiving regular turns. The pressure injury was not reported via the incident reporting procedures (link #1.2.4.2).

Interventions in four long term care plans reviewed were comprehensive; resident focused and detailed the care and monitoring requirements for those residents. Care staff interviewed advised that they read the care plans and an initial care plan is written to guide staff prior to the long term care plan being developed (exception of one respite resident link finding #1.3.5.2).

Wound care education was last provided in August 2013.

Five residents and six family members (two rest home and four dementia) interviewed confirm their current care and treatments they and their family members are receiving meet their needs. On tour of facility it was observed one rest home resident required a higher level of care than what is expected at rest home level .

Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed.

All falls are reported on the resident accident/incident form and reported to the nurse manager. A physiotherapist referral can be initiated as required.

There is one full time nurse manager employed by the service. A record of all health practitioners practicing certificates is kept.

Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a nurse manager with exceptions (link finding #1.3.4.2). Care plans are goal orientated and reviewed at six monthly intervals (where completed – link finding #1.3.5.2). 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.

Short term care plans are available for use for changes in health status – these require improvements (link finding #1.3.5.2).

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

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

**Attainment and Risk:** FA

### **Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The activities programme is provided five days a week for three hours per day. The diversional therapist (DT) allocates one hour for rest home residents and two hours for dementia residents and has one extra hour per week for administration. There is a monthly activity planner. A range of activities are available and these include the involvement of the residents into the community. The programme reflects resident's interest in the environment and they have choice in their level of participation. Activities include (but are not limited to): outings, exercise programmes, music, arts and crafts, games, and reminiscing, monthly church services, monthly visits from local childcare, quizzes, weekly entertainment, bowls, newspaper reading, and seasonal celebrations. One-to-one support is provided in situations where residents are unable to participate in group activities. Care staff assist in providing diversional therapy and activities in the dementia when the DT is not on duty and have access to resources. A resident social profile is completed as evidenced in six permanent resident files reviewed. Resident activities assessment form includes skills, interests and involvements in community activities. Activities care plan includes; a) preferred activities, b) goals and objectives for physical, sensory, cognitive / intellectual and social, religious / spiritual / cultural, and c) suggested individual diversional activities. Attendance records are maintained for each individual. Five residents interviewed spoke positively of the programme. Activities are discussed with residents to ensure that the activity programme is appropriate for the residents who currently reside at Ashlea Grove. The diversional therapist stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions. Resident files reviewed identified that the individual activity plan is reviewed six monthly.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Initial care plans were developed by a nurse manager on day of admission (with exception of one respite resident link finding #1.3.5.2) and resident comprehensive long term care plans developed within three weeks of admission for four permanent residents (two rest home and two dementia link finding #1.3.5.2). Completed long term care plans are evaluated however; the six month time frame has not been adhered to (link finding #1.3.3.3). Each aspect of the long term care plan is evaluated and updates are noted on the long term care plans reviewed. Care plan reviews are signed as completed by a RN. GPs review residents three monthly or when requested if issues arise or health status changes. 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 confidence in the management of the residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other medical and non-medical services. The GP interviewed confirms the nurse manager informs the practice of any referrals made directly to other nursing services or the needs assessment team including district nursing services, vascular clinic, and mental health for older person's nurse practitioner. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted. However, it was noted that four residents residing in Ashlea Grove are receiving a higher/different level of care than would be expected and the service is required to ensure that a referral for reassessment is instigated. Relatives (two rest home, four dementia) and residents (five rest home) interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.

There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA High

### **Evidence:**

The medication management system includes a medication policy and procedures that requires improvement (link finding #1.2.3.3). The service uses a four weekly packed medication system provided by a local pharmacy which is checked by the nurse manager against the medication order. The pharmacy generates medication charts which includes a picture of each tablet and the indications for use.

All residents have individual medication charts with photo ID, and three monthly reviews of medication are conducted by a GP. Improvements are required whereby all medication orders are signed by the prescriber and allergies or nil known allergies are recorded. There are two medication trolleys- one in the rest home area and one in the dementia unit. Medication charts are kept in a folder in each area. Controlled drugs are stored in a locked box in a locked cupboard – one in each area. The keys for the dementia unit cupboard were noted to have been left on the bench. Improvement is required in this area. On review of the controlled drug register, it was noted that regular weekly controlled drug checks have not routinely been conducted. Improvements are required in this area. At the front of each medication folder is a transcribed list of prn and non-packed medications for each resident. This is an area which requires improvement. Standing orders are utilised for 'over the counter' type medications which were last reviewed in June 2013. Improvements are required in this area.

Caregivers administer medications to residents. Two caregivers were observed administering medications – one rest home and one dementia. Correct procedure was not followed by one care giver, in that the staff member signed for the medications prior to the resident taking them.

Medication competency assessment comprises the staff member completing a questionnaire which was last completed in March 2013. There is no evidence of observation of practice as part of this assessment. Improvements are required in this area. Medication training was last provided in April 2013.

Medication audits were last conducted in August 2013 (link finding #1.2.3.6). Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. There was no gaps in signing for administration sheets reviewed for 14 medication charts reviewed (six rest home and eight dementia).

The service is required to make improvements around self-medicating resident's policy (link finding #1.2.3.3). Advised there are no residents currently self-medicating. The service has in place and has implemented systems to ensure adverse reactions and administration errors are identified and appropriate intervention occurs. There is a staff signature identification sheet in the front of the medication folders.

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

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

**Attainment and Risk:** PA High

### **Evidence:**

The medication management system includes a medication policy and procedures that requires improvement (link finding #1.2.3.3). The service uses a four weekly packed medication system provided by a local pharmacy which is checked by the nurse manager against the medication order. The pharmacy generates medication charts which includes a picture of each tablet and the indications for use.

All residents have individual medication charts with photo ID, and three monthly reviews of medication are conducted by a GP. There are two medication trolleys- one in the rest home area and one in the dementia unit. Medication charts are kept in a folder in each area. Controlled drugs are stored in a locked box in a locked cupboard – one in each area. Caregivers administer medications to residents. Two caregivers were observed administering medications – one rest home and one dementia.

**Finding:**

Medications charts for three of six rest home and one of eight dementia residents are not signed by the prescriber

Controlled drug order for one dementia resident on regular XXXXX is not recorded on the current medication chart. Advised that the charts are generated from the local pharmacy and this has been left off in error. The prescription for this medication is current. Advised that the pharmacist has been notified to make an amendment to this order. This will then require signing by the GP.

Standing orders are out of date- last reviewed on 3 July 2013.

Transcribing of non-packaged and PRN medication orders has occurred on to a front sheet in each medication folder. This form has been generated to guide staff.

One caregiver was observed during a lunch time medication round and was noted to have signed the medication administration sheet prior to administering the medications.

Medication cupboards are locked and controlled drugs are stored securely in a locked box – one in each area of service. However, the keys to the cupboard and controlled drugs box were left unattended on the nurse's desk in the dementia unit during the audit.

On review of the controlled drug register, it was noted that regular weekly controlled drug checks have not routinely been conducted.

**Corrective Action:**

a) Ensure that all medication orders are signed by the prescriber; b) Ensure that all medications administered to residents have a corresponding order; c) Review standing orders annually as per medication guidelines; d) Cease transcribing of medication orders; e) Ensure that all staff with administration responsibilities follow correct administration procedures; f) Ensure that medication storage security is maintained at all times; g) Ensure that weekly checks of all controlled drugs are undertaken.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication competency assessment comprises the staff member completing a questionnaire which was last completed by caregivers in March 2013. Advised by the nurse manager that she has completed syringe driver training and competency. Medication training was last provided in March 2013.

**Finding:**

Medication competencies have not been conducted in the past 12 months and observation of practice is not recorded. The registered nurse does not have a current medication competency completed.

**Corrective Action:**

Ensure that all staff that have responsibilities for administering medications are assessed annually, including a documented observation of practice.

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

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

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

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

**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.

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

**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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> There is a small functional kitchen at Ashlea Grove. All food is cooked on site. The service provides meals on wheels to the community and the local district council signed off an annual registered commercial kitchen audit. The service employs a cook who is supported by a weekend cook and care staff. Advised that both cooks have completed

safe food handling training. A cleaning schedule is maintained. There are two fridges and a large chest freezer in the kitchen and another fridge and freezer in a storage area. The kitchen has a well-stocked pantry, electric range, electric oven and microwave. The service has a four week winter and summer menu that was last reviewed by a dietitian in June 2014.

The service has a four week winter and summer menu that was last reviewed by a dietitian in June 2014. Resident files reviewed show evidence of dietary profile documented on admission and sent through to the kitchen. This is updated as residents need change as evidence in the folder of profiles reviewed. Nutritional assessments have not been conducted (link #1.3.4.2) however, one resident is receiving ensure supplement drinks for identified weight loss and low appetite. The service has lipped plates and modified utensils available for residents. Textures of foods can be modified to suit the resident needs. One dementia resident was receiving thickened fluids. Advised by the cook that special diets are catered for, for example one resident is a vegetarian. The cook prepares vegetarian dishes for this resident

One resident in the dementia unit requires assistance with her meals and drinks. The resident was observed to be fed her lunch time meal by another resident (rest home) who visits the dementia unit daily for socialisation. Staff (two) were noted to be in the dining room during meal service serving and assisting other residents. Improvement is required.

Fridge temperatures are recorded morning and afternoon and freezer temperatures are monitored and recorded monthly. Each fridge and freezer has a thermometer in it for staff to check each day. Advised by the cook that the hot food for the meal is placed in serving dishes, which are preheated, then transported to the rest home dining room on a trolley for serving to the rest home residents. The trolley is then wheeled to the dementia unit and the residents there are served their meals. The meal service was observed in the dementia unit.

#### **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:** PA Low

**Evidence:**

The service has a four week winter and summer menu that was last reviewed by a dietitian in June 2014. Resident files reviewed show evidence of dietary profile documented on admission and sent through to the kitchen. This is updated as residents needs change as evidence in the folder of profiles reviewed. Nutritional assessments have not been conducted (link #1.3.4.2) however, one resident is receiving ensure supplement drinks for identified weight loss and low appetite. The service has lipped plates

and modified utensils available for residents. Textures of foods can be modified to suit the resident needs. One dementia resident was receiving thickened fluids. Advised by the cook that special diets are catered for, for example two residents are vegetarian. The cook prepares vegetarian dishes for these residents.

**Finding:**

One resident in the dementia unit requires assistance with her meals and drinks. The resident was observed to be fed her lunch time meal by another resident (rest home) who visits the dementia unit daily for socialisation. Staff (two) were noted to be in the dining room during meal service serving and assisting other residents.

**Corrective Action:**

Ensure that all residents' nutritional needs are met and that residents are safely and appropriately assisted with their meals and drinks by care staff only.

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

**Evidence:**

There is a small functional kitchen at Ashlea Grove. All food is cooked on site. The service provides meals on wheels to the community and the local district council signed off an annual registered commercial kitchen audit. The service employs a cook who is supported by a weekend cook and care staff. Advised that both cooks have completed safe food handling training. A cleaning schedule is maintained. There are two fridges and a large chest freezer in the kitchen and another fridge and freezer in a storage area. The kitchen has a well-stocked pantry, electric range, electric oven and microwave. The service has a four week winter and summer menu that was last reviewed by a dietitian in June 2014.

Fridge temperatures are recorded morning and afternoon and freezer temperatures are monitored and recorded monthly. Each fridge and freezer has a thermometer in it for staff to check each day. Advised by the cook that the hot food for the meal is placed in serving dishes, which are preheated, then transported to the rest home dining room on a trolley for serving to the rest home residents. The trolley is then wheeled to the dementia unit and the residents there are served their meals. The meal service was observed in the dementia unit.

**Finding:**

a) Food items (four) in one chest freezer were noted not be covered and dated; b) Hot food is transported to the rest home and dementia dining rooms for serving. The service does not monitor if the food is kept hot during the serving of meals; c) The service only records hot food temperatures twice a month prior to leaving the kitchen.

**Corrective Action:**

a) Ensure all food stored in the fridges and freezers is covered and dated; b) Provide a food service system that maintains hot food at the optimum temperature to ensure that food safety is not compromised; c) Conduct food temperature checks for each hot food dish prior to serving.

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals, however, it is noted that cleaning chemicals are stored on the shelves of one toilet in the dementia unit and in the nurses cupboard of the dementia unit. An improvement is required. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with four caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in August 2013.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals. Product use charts are available. Hazard register identifies hazardous substance.

**Finding:**

Cleaning chemicals were observed to be stored on the shelves of one toilet in the dementia unit and in the nurse's cupboard of the dementia unit which is not locked.

**Corrective Action:**

Ensure that all chemicals are stored safely and securely.

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

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

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service displays a current building warrant of fitness which expires on 12 July 2015. Hot water temperatures checks are conducted and recorded monthly by the maintenance person and were sighted to be managed within the appropriate temperature range. The building is over 90 years old. A maintenance person is employed for three days per week. Testing and tagging of electrical equipment has been conducted in November 2013 and the sling hoist was last checked in February 2014. There is a requirement whereby medical equipment including scales are calibrated by an authorised technician. The interior of the building is generally well maintained with a home-like décor and furnishings. There is a large communal lounge and dining area in each area, and communal bathroom and toilet facilities. There are small seating nooks available for residents and visitors. The corridors are wide with handrails in place. There is an external designated smoking area. There is easy access to the outdoors. Outdoor ramps have handrails. The dementia unit has a secure garden. The exterior is reasonably maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with four caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. It is noted that medical equipment has not been calibrated. On a tour of the facility it was noted that in one communal bathroom in the rest home has areas where the floor coverings have lifted and bubbled creating a trip hazard. Improvements are required in this area.

The service has extended the dementia unit to include three extra rooms. A new partition wall has been built which includes a keypad locked door between the dementia unit and the rest home. The three rooms, communal spaces and toilet facilities are able to cater for three extra dementia care residents.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

The service displays a current building warrant of fitness which expires on 12 July 2015. Hot water temperatures checks are conducted and recorded monthly by the maintenance person and were sighted to be managed within the appropriate temperature range. The building is over 90 years old. A maintenance person is employed for three days per week. Testing and tagging of electrical equipment has been conducted in November 2013 and the sling hoist was last checked in February 2014.

**Finding:**

Medical equipment including thermometers, blood pressure machines and sit on scales have not been calibrated and checked for accuracy.

**Corrective Action:**

Ensure that all medical equipment is calibrated by an authorised technician.

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

**Evidence:**

The interior of the building is generally well maintained with a home-like décor and furnishings. There is a large communal lounge and dining area in each area, and communal bathroom and toilet facilities. There are small seating nooks available for residents and visitors. The corridors are wide with handrails in place. Residents were observed to safely mobilise throughout the facility. There is an external designated smoking area. There is easy access to the outdoors. Outdoor ramps have handrails. The dementia unit has a secure garden. The exterior is reasonably maintained with safe paving, outdoor shaded seating, lawn and gardens. Environmental audit completed in June 2014 with corrective actions recorded around the lifted vinyl in one bathroom.

**Finding:**

On a tour of the facility it was noted that in one communal bathroom in the rest home area has a portion of the floor covering that has lifted and bubbled creating a trip hazard.

**Corrective Action:**

Ensure that all hazards, such as uneven floor surfaces, are managed appropriately (minimise, isolate, eliminate) to provide a safe environment for residents and staff.

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

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

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

**Attainment and Risk:** FA

**Evidence:****Finding:****Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

Six rooms in the rest home have their own ensuite; the remainder of the rooms (rest home and dementia units) have shared facilities. The number of toilets and showers provided is adequate. There are adequate toilet/showering facilities in the dementia unit to cater for the three extra rooms. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Five rest home residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene, however, it is noted that one communal toilet in the dementia unit does not have a door (curtain only) and one toilet in the rest home has no privacy locks attached (link finding #1.1.3.1).

Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets (also noted that some toilets have hand towels as well link finding #3.1.9). Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. One resident's room carpet floor covering in the dementia unit requires cleaning (link finding #1.4.6.2). The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs for all but one toilet.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. The three extra rooms in the dementia unit are able to cater for residents requiring dementia level care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is a large lounge and dining room in each unit. The dining rooms are spacious, with the kitchen located directly and is adjacent to the dementia unit. This space is able to cater for the three extra residents. There is a small kitchenette in the rest home dining room located directly off the kitchen/servery area. Food is delivered to dementia unit dining room at meals times. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and four residents interviewed report they can move around the facility and staff assist them if required.

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

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Ashlea Grove has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer's data safety charts are available. Five residents and six family (two rest home and four dementia) interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Laundry and cleaning audit last conducted in July 2014. On a tour of the facility it was noted that one resident room in the dementia unit has a strong urine odour from the floor covering. Improvement is required 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:** PA Low

**Evidence:**

Ashlea Grove has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Care staff complete cleaning/laundry tasks. Manufacturer's data safety charts are available. Five residents and six family (two rest home and four dementia) interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Laundry audit conducted in February 2014 and cleaning audit conducted in October 2013.

**Finding:**

On a tour of the facility it was noted that one resident room in the dementia unit has a strong urine odour from the floor covering. Advised that the service is aware of this issue and corrective actions are underway.

**Corrective Action:**

Ensure that the facility cleanliness and hygiene is maintained and that the service is free from odours.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency plan training occurred in December 2013. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the 6 May 2003. The last fire evacuation drills occurred 8 July 2014 however these have not been conducted six monthly (# link 1.2.7.5). Staff in-service for civil defence emergencies was held December 2013. Battery operated emergency lighting, extra torches and gas barbeque for cooking is available however there is no gas bottle onsite for the BBQ. This is an area requiring improvement. The service is able to obtain a generator from within the community if required in an emergency. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. Security policies and procedures are in place. There is a civil defence kit available. The service has extra food and water available should the need arise.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Battery operated emergency lighting, extra torches and gas barbeque for cooking is available

**Finding:**

There is no gas bottle onsite for the BBQ.

**Corrective Action:**

Ensure that there is a gas bottle available for emergency use at all times.

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

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

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Four residents and five family interviewed state the environment is warm and comfortable. The facility is heated via a radiator boiler system which provides heating and hot water.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## 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:**

Ashlea Grove has comprehensive policies and procedures on restraint minimisation and safe practice. The nurse manager is the restraint coordinator and confirms that the service promotes a restraint-free environment.

Policy states that enablers are voluntary. There are no residents using enablers and one dementia resident assessed as requiring a lap belt restraint and one rest home resident with environmental restraint. Environmental restraint is also in use in the rest home. The facility doors are locked late each afternoon to prevent/deter a rest home resident from leaving the service. This resident has a degree of dementia and confusion. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers. The restraint policies relating to restraint record environmental restraint as a classification of restraint but is not recorded in the list of approved restraints. Improvements are required in this area. Restraint education last provided for staff in May 2012 and is scheduled for 2014. Staff have completed restraint questionnaire and competency

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Policy states that enablers are voluntary. There are no residents using enablers and one dementia resident assessed as requiring a lap belt restraint and one rest home resident with environmental restraint. Environmental restraint is also in use in the rest home. The facility doors are locked late each afternoon to prevent/deter a rest home resident from leaving the service. This resident has a degree of dementia and confusion. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers and types of restraint permitted including lap belts and bedrails. The restraint policies relating to restraint record environmental restraint as a classification of restraint, but is not recorded in the list of approved restraints.

**Finding:**

The use of environmental restraint is not listed in restraint policy as an authorised form of restraint.

**Corrective Action:**

Conduct a review of restraint minimisation and safe practice policies and procedures to include environmental restraint.

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes key responsibilities for the restraint coordinator, who is also the nurse manager (RN). Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers. Environmental restraint is classified as restraint but is not listed as an approved form of restraint in facility restraint policies and procedures. Restraint use is a regular agenda item in quality/staff meetings. Restraint use approval group is part of the quality assurance committee. One resident in the dementia unit has been assessed as requiring restraint (lap belt) for occasional use, and one rest home resident is placed in the dementia unit during the day (environmental restraint). When this resident returns to the rest home in the late afternoon the front door of the rest home is locked to prevent/deter her from leaving. This resident has a degree of dementia and confusion. Environmental restraint is also imposed on the other rest home residents as they are unable to leave by the front door once it is locked. Improvements are required in this area. Staff interviews confirm their understanding of using the restraint for one dementia resident only as a last resort, is not used for behaviour control and is used as a falls prevention measure and for resident safety and security. Documentation includes restraint register, restraint assessment form for one dementia resident, restraint authorisation and consent form for one dementia resident, a restraint plan in the dementia resident's care plan, monitoring forms, and evaluation forms as evidenced in the one dementia resident file reviewed. The rest home resident on environmental restraint (admitted in April 2014) has not been assessed for the environmental restraint, has no completed authorisation and consent and has no long term care plan developed (link finding #1.3.5.2). Improvement is required in this area.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes key responsibilities for the restraint coordinator, who is also the nurse manager (RN). Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers. Environmental restraint is classified as restraint but is not listed as an approved form of restraint in facility restraint policies and procedures. Staff interviews confirm their understanding of using the restraint only as a last resort, is not used for behaviour control and is used as a falls prevention measure and for resident safety and security. Documentation includes restraint register, restraint assessment form for one dementia resident, restraint authorisation and consent form for one dementia resident, a restraint plan in the dementia resident's care plan, monitoring forms, and evaluation forms as evidenced in the one dementia resident file reviewed.

**Finding:**

a) One rest home resident (admitted in April 2014) has not been assessed for the environmental restraint, has no completed authorisation and consent and has no long term care plan developed in which to include the environmental restraint; b) Environmental restraint is imposed on other rest home residents without their consent.

**Corrective Action:**

a) and b) Ensure that appropriate approval for all restraint is use is obtained and documented prior to restraint use.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Assessments are undertaken by the nurse manager in conjunction with the GP and family of the one dementia resident with authorised restraint. The restraint assessment and authorisation has been reviewed by the restraint coordinator (nurse manager) as sighted in the one dementia resident file sampled (lap belt). The file identified that restraint assessment has been conducted and last reviewed on 27 July 2014. Consent forms are completed for the one dementia resident requiring lap belt restraint. One rest home resident with environmental restraint has no restraint assessments completed and no long term care plan (link finding #1.3.4.2, #1.3.5.2). Improvements are required in this area.

Assessments are undertaken by the nurse manager in conjunction with the GP and family of the one dementia resident with authorised restraint. The restraint assessment and authorisation has been reviewed by the restraint coordinator (nurse manager) as sighted in the one dementia resident file sampled (lap belt). The file identified that restraint assessment has been conducted and last reviewed on 27 July 2014. Consent forms are completed for the one dementia resident requiring lap belt restraint. One rest home resident with environmental restraint has no restraint assessments completed and no long term care plan (link finding #1.3.4.2, #1.3.5.2). Improvements are required in this area.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Attainment and Risk:** PA Moderate

**Evidence:**

Assessments are undertaken by the nurse manager in conjunction with the GP and family of the one dementia resident with authorised restraint. The restraint assessment and authorisation has been reviewed by the restraint coordinator (nurse manager) as sighted in the one dementia resident file sampled (lap belt). The file identified that restraint assessment has been conducted and last reviewed on 27 July 2014. Consent forms are completed for the one dementia resident requiring lap belt restraint.

**Finding:**

One rest home resident with environmental restraint does not have assessment documentation completed for this type of restraint. The resident goes to the dementia unit every day and returns to the rest home unit in the evening for her evening meal and to sleep in her room.

**Corrective Action:**

Ensure all restraint use is appropriately assessed and documented prior to use.

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

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

Services use restraint safely

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The nurse manager is the restraint co-ordinator. She receives advice and input from the resident's general practitioner and family/whanau.

The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service.

Approved restraints include lap belts and bedside rails.

One dementia resident file with restraint was reviewed – for a lap belt to be used in a wheelchair when the resident is restless and at risk of mobilising without assistance.

There is evidence that the resident's care plan includes reference to the restraint. Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome. Restraint monitoring forms are in place. Restraint was last used in March 2014.

The service has a restraint register that records sufficient information to provide an auditable record of restraint use for the individual. Advised by the nurse manager that a resident from the rest home spends each day in the dementia unit. This is recorded in progress notes reviewed for this resident. The resident goes to the dementia unit with encouragement from staff and returns to the rest home area for the evening meal and to sleep in her room. At this time, the rest home front door is locked to dissuade the resident from leaving (as has happened in the past). Improvements are required in this area.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** PA Low

#### **Evidence:**

One resident file with restraint was reviewed – for a lap belt to be used in a wheelchair when the resident is restless and at risk of mobilising without assistance. There is evidence that the resident’s care plan includes reference to the restraint. Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome. Restraint monitoring forms are in place. Restraint was last used in March 2014. The service has a restraint register that records sufficient information to provide an auditable record of restraint use for the individual.

#### **Finding:**

Advised that a resident from the rest home spends each day in the dementia unit. The resident goes there by choice and returns to the rest home area for the evening meal and to sleep in her room. There is no record of this type of restraint being used in the resident’s file. No long term care plan has been developed (link #1.3.5.2).

#### **Corrective Action:**

Where restraint is in use, ensure that this is recorded as part of the care planning process.

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator or RN on duty reassesses each resident using restraint for their on-going restraint needs.

The restraint coordinator monitors the review of safe restraint practice. A system of evaluation and review of the restraint for the resident takes place three-monthly. This review assesses the following: alternative strategies explored, desired outcome and whether it is being achieved, whether the restraint used is the least restrictive option, the duration of the restraint, the impact the restraint has on the resident, and were policies and procedures followed. Family/whanau participate in evaluations. Use of restraint is discussed at quality meetings (meeting minutes sighted) and at three monthly clinical reviews for each resident. One dementia resident with restraint was reviewed in July 2014 and one rest home resident file with environmental restraint has a review recorded on file. This evidences that the nurse manager, GP and nurse practitioner for mental health for older persons has discussed and recorded the restraint use (conducted in April 2014 and July 2014).

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** PA Low

**Evidence:**

Ashlea Grove rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by the nurse manager. The nurse manager is the service infection control nurse. The management team and staff meeting incorporates the infection control committee (# link 1.2.3.5). Discussion and reporting of infection control matters and consequent review of the programme is conducted at these meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning (# link 1.2.3.6). Annual education is provided for all staff (last provided February 2014). The annual review of the programme has been conducted in June 2014. Hand washing facilities are available for staff, residents and visitors throughout the facility; however there are no disposable hand towels available in a toilet in the dementia area (the service uses cloth towels). There are uncovered supplies of towels stored in the bathrooms for use following showers which do not meet best practice for infection prevention and control measures. This is an area requiring improvement. Signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Hand washing facilities are available for staff, residents and visitors throughout the facility. Signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised

**Finding:**

(i) There are no disposable hand towels available in a toilet area in the Dementia unit (the service uses cloth towels). (ii) There are uncovered supplies of towels stored in the bathrooms for use following showers which do not meet best practice for infection prevention and control measures.

**Corrective Action:**

(i) and (ii) Ensure that there are supplies of disposable hand towels and ensure that towels are not stored in bathrooms uncovered.

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The nurse manager is the infection control (IPC) nurse. She is supported by the owner and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IPC nurse and staff have good external support from the local laboratory infection control team, the medical practice and IPC nurse expert at Southern DHB. The infection control team is representative of the facility.

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

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

**Attainment and Risk:** FA

**Evidence:****Finding:****Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are infection control policy and procedures appropriate to for the size and complexity of the service.

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the nurse manager to ensure best practice information is included. The policies and procedures were last updated and reviewed in June 2014. Ashlea Groves infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection prevention and control nurse (nurse manager). The nurse manager has attended bug control seminar in 2013, and DHB facilitated "outbreak management" sessions in 2013 and 2014. All infection control training is documented and a record of attendance is maintained. Infection control education was provided in February 2014 in relation to hand washing and hand hygiene. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been recorded in the past two years. Staff have attended in-service on outbreak management (June 2013). Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

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

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

**Attainment and Risk:** FA

**Evidence:**

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**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Ashlea Grove's infection control programme. Monthly infection data is collected for infections that are treated with antibiotics only. This is an area requiring improvement. Infections are recorded on short term care plans however there is no evidence that signs and symptoms of infection, treatment, follow up, and resolution are completed as evidenced in two short term care plans sighted for March and April 2014. This is an area requiring improvement. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the management meetings and staff meetings (# link 1.2.3.5). If there is an emergent issue, it is acted upon in a timely manner. No outbreaks were noted in the past two years.

#### **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:** PA Low

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Ashlea Grove's infection control programme. Infections are recorded on short term care plans. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the management meetings and staff meetings (# link 1.2.3.5). If there is an emergent issue, it is acted upon in a timely manner. No outbreaks were noted in the past two years.

**Finding:**

(i) Monthly infection data is collected for infections that are treated with antibiotics only. (ii) Infections are recorded on short term care plans however there is no evidence that signs and symptoms of infection, treatment, follow up, and resolution are completed as evidenced in two short term care plans sighted for March and April 2014.

**Corrective Action:**

(i) Ensure that all infections based on signs and symptoms of infection are recorded. (ii) Ensure that all infections have documented signs and symptoms, treatment, follow up and resolution completed.

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