

Springvale Manor Limited

Current Status: 7 July 2014

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

General overview

Springvale Manor provides care for up to eight rest home and 20 residents requiring dementia level care. On the day of audit there are eight rest home residents and 12 residents in the dementia unit. Springvale Manor is managed by an experienced manager, who is supported by a registered nurse and an experienced team of home assistants. There are developed systems to provide quality care for residents. There is an orientation and training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The shortfalls from the certification audit around updating policy, corrective action planning, training attendance records, controlled drug management, hot water temperature management have been closed out. The following shortfalls from the partial provisional audit in January 2014 have also been closed out – business planning, aspects of medication management, food services and environmental improvements.

This audit identified areas of improvement around incident reporting, training, documentation, activities, medication management, food services, equipment and restraint.

Audit Summary as at 7 July 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	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 7 July 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 7 July 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 7 July 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 7 July 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		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 7 July 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 7 July 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Springvale Manor Limited
Certificate name:	Springvale Manor Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
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Types of audit:	Surveillance Audit
Premises audited:	Springvale Manor Rest Home
Services audited:	Rest home care (including dementia care)
Dates of audit:	Start date: 7 July 2014 End date: 7 July 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	20
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Audit Team

Lead Auditor	XXXXXXX	Hours on site	9.15	Hours off site	6
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Other Auditors	XXXXXX	Total hours on site	9.15	Total hours off site	5
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	18.3	Total audit hours off site	13	Total audit hours	31.3
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Number of residents interviewed	6	Number of staff interviewed	9	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	24	Number of relatives interviewed	2
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	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 7 August 2014

Executive Summary of Audit

General Overview

Springvale Manor provides care for up to eight rest home and 20 residents requiring dementia level care. On the day of audit there are eight rest home residents and 12 residents in the dementia unit. Springvale Manor is managed by an experienced manager, who is supported by a registered nurse and an experience team of home assistants. There are developed systems to provide quality care for residents. There is an orientation and training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The shortfalls from the certification audit around updating policy, corrective action planning, training attendance records, controlled drug management, hot water temperature management have been closed out. The following shortfalls from the partial provisional audit in January 2014 have also been closed out – business planning, aspects of medication management, food services and environmental improvements.

This audit identified areas of improvement around incident reporting, training, documentation, activities, medication management, food services, equipment and restraint.

Outcome 1.1: Consumer Rights

There is an open disclosure policy. Interviews with residents and relatives confirm family are kept informed of their family members current health status including any adverse events. A complaints process is implemented.

Outcome 1.2: Organisational Management

The service continues to implement a quality and risk management framework that includes management of incidents, complaints, and infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. There is an appropriately experienced manager who provides guidance for the service and is supported by a registered nurse, enrolled nurse and experienced home assistants. The registered nurse provides clinical oversight during weekdays and there is available after hours. There is an in-service training schedule. The service has sufficient staff allocated to enable the delivery of care. There are three areas of improvement relating to incident reporting, training and documentation.

Outcome 1.3: Continuum of Service Delivery

Service provision occurs in a timely manner. The registered nurse coordinates the care for all residents. All of the residents use the same general practitioner who visits at least weekly and reports confidence in clinical decision making. Group and individual activities programmes are provided every day during the week. Residents are evaluated shortly after admission and then three monthly or earlier if their health changes. Medicines are administered by the registered nurse, enrolled nurse or senior caregivers who have been assessed as competent. The service has addressed one of the service delivery shortfalls from their previous certification audit around controlled drug storage and has addressed previous shortfalls identified at the provisional audit around medicine storage. Further improvements continue to be required around medicines management, food services, activities and appropriate equipment.

Outcome 1.4: Safe and Appropriate Environment

The building has a current building warrant of fitness which expires 22 June 2015. The service has addressed one of the shortfalls from their previous certification audit around safe water temperatures. A further improvement continues to be required around the calibration of scales.

Outcome 2: Restraint Minimisation and Safe Practice

The service aims to minimise restraint practices. The registered nurse oversees the use of restraints and enablers. There is one restraint and no enablers in use. This audit identified an improvement around restraint practices.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (registered nurse) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies and guidelines to support practice. Infection control activities include audits of the facility, hand hygiene and surveillance of infection control events and infections.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	7	0	7	4	0	0
Criteria	0	37	0	7	4	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	32
Criteria	0	0	0	0	0	0	0	53

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		consumers.				
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	There was noted to be examples of unprofessional subjective statements within the business plan.	Ensure the business/quality plan identifying goals, timeframes and responsibilities that are objective, measureable, and professional	90
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 Low			
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 Low	18 incident forms were reviewed across 2014. There were two forms in use, one of which does not have a section to indicate if family are notified (link evidence 1.1.9), and two forms did not have registered nurse sign out.	There is one incident form used to report resident incidents – preferably including family notification – and all reported incidents are reviewed and signed off by the registered nurse.	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			
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	The infection control coordinator (registered nurse) informed infection control training is provided at staff meetings (minutes recorded state hand washing discussed), however there is no evidence of content and evaluation – this was a finding from the previous certification audit. In addition infection control was scheduled to be delivered in June, however this did not occur (refer evidence 3.5). The infection control	Deliver infection control training and evaluate its effectiveness	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				coordinator reported a staff questionnaire is completed, in the seven staff files reviewed there were four completed questionnaires dated 2012. As this is a recurring matter, and the service has recently experienced a gastro infection affecting residents and staff, the risk rating is considered to be moderate.		
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 Low			
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 Low	In the weekend there are only two caregivers on in the morning shift. It was noted #2.2.3.2 that a lapbelt is used for the safety of a resident when staff are busy.	Ensure staffing in the dementia unit is reviewed to align with ARC E4.5 and to ensure residents can be safely supervised	90
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	In the five files reviewed staff use 'am', 'pm' to record time of entry, and designation is inconsistently recorded.	Record the time of entry and designation in the resident progress notes	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Staff cannot access sitting scales to weigh residents who are unable to stand unaided on the existing floor scales.	Ensure there is sufficient equipment to meet the needs of residents (ARC D15.3).	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Individual activities plans are not reviewed at the same time as the resident's plan of care is reviewed.	Ensure that the individual activities programme for each resident is reviewed at the same time as their plan of care is reviewed (ARC D16.5ciii).	30
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 Low			
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 Low	Controlled drugs are not being checked weekly, which remains an improvement from the previous audit, and standing orders for medicines do not comply with the guidelines published by the Ministry of Health 2012, which is a new identified improvement.	Ensure controlled drugs are checked weekly and the practice of standing orders complies with the guidelines published in 2012 by the Ministry of Health.	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 Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Food temperatures are taken with a probe but not recorded and therefore could not be evidenced.	Develop and implement a system of food temperature monitoring.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Moderate	The floor scales in use have not been calibrated by an external provider with expertise in calibration techniques. This remains an improvement from the previous audit.	Ensure the floor scales are calibrated by an expert.	30
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	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.	PA Moderate	An unauthorised restraint was observed in the form of a bedrail for a resident living in the dementia unit to prevent her falling out of bed when caregivers were busy, and monitoring documentation for another resident living in the dementia unit was incomplete.	Ensure care staff do not practice unauthorised restraint and ensure restraint documentation is complete for the duration of intermittent restraints.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. There are two incident forms in use, one of which does not have an area to indicate if family have been informed (or not) of an accident/incident (link 1.2.4). 18 incident forms were reviewed across 2014, and while nine did not report family were notified on the form, there is evidence in progress notes that family are notified following a resident incident. Interview with two caregivers (who work across the rest home and dementia unit) and the registered nurse inform family are kept informed. Relatives interviewed (one rest home, one dementia) confirm they are notified following a resident incident. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Relatives (one rest home and one dementia) stated that they are informed when their family members health status changes. D11.3: The information pack is available in large print and this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a complaints policy to guide practice. The policy includes reference to Right 10 of the Health and Disability Commissioners Code of Consumer Rights and the finding from the previous certification audit is now met. The manager leads the investigation and management of complaints (verbal and written). Complaints are discussed at the monthly staff meeting. The last recorded complaint is a letter to the Health and Disability Commissioner (HDC) dated June 2014. The complaint had been received by the Ministry of Health, investigated by the District Health Board and outcome sent to HDC. A response is yet to be received from the latter. The only other complaint for 2014 is dated May 2014, and is seen to have been investigated and closed out letter sent to the complainant. Discussion with six residents and two relatives (one rest home and one dementia) confirm they are aware of how to make a complaint. D13.3h. a complaints procedure is provided to residents within the information pack at entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Springvale Manor Limited is the proprietor of Springvale Manor. Three directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. The directors meet three monthly. The manager is able to describe the company financial and business goals. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2014-2015 Business Plan that outlines objectives for the period and this is an improvement on previous audit.. There is an improvement required around the wording and content of the business plan.

Springvale Manor provides care for up to 28 residents across two service levels (rest home and dementia). On the day of audit there were eight (of eight) rest home residents and 12 (of 20) residents in the dementia unit. There is a quality programme in place that includes discussion about clinical indicators (e.g. incident trends, infection rates), at

the monthly staff meeting. The owner/manager (non-clinical) full time who is supported by a registered nurse who works 30 hours/week. The owner/manager has been in post for five years. There is a team of experienced care staff
D17.3di, the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

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: PA Low

Evidence:

Three directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. The directors meet three monthly. The manager is able to describe the company financial and business goals. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2014-2015 Business Plan that outlines objectives for the period and this is an improvement on previous audit

Finding:

There was noted to be examples of unprofessional subjective statements within the business plan.

Corrective Action:

Ensure the business/quality plan identifying goals, timeframes and responsibilities that are objective, measureable, and professional

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Springvale Manor is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed in line with best practice, and the manuals are updated when policies have been reviewed. There is an open disclosure policy. The finding from the certification audit relating to updating manuals when policy updates are received from Care Association New Zealand (CANZ), and having an open disclosure policy has now been met. The content of policy and procedures are detailed to allow effective implementation by staff.

Quality matters are taken to the monthly staff meetings that all staff are invited to attend. Meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings (monthly).

Springvale Manor is implementing an internal audit programme that includes aspects of clinical care – such as care plan audit. Issues arising from internal audits are seen to have been addressed. The finding from the certification audit relating to corrective actions is now met.

D19.3: There is an H&S and risk management programme in place including policies to guide practice. The registered nurse is the health and safety coordinator for the facility who monitors staff accidents and incidents.

D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the staff meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse (RN) at the time of event if she is on site, and is notified by home assistants if incidents afterhours. Family are notified by the registered nurse. 18 incident forms were reviewed across 2014. There were two forms in use, one of which does not have a section to indicate if family are notified (link evidence 1.1.9), and two forms did not have registered nurse sign out. These are areas for improvement. One file was reviewed (dementia) and all reported incidents had an accompanying incident form. The finding from the certification audit relating to family notification and availability of an open disclosure policy have been closed out (link evidence 1.1.9).

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: PA Low

Evidence:

Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event if she is on site, and is notified by home assistants if incidents afterhours. Family are notified by the registered nurse. 18 incident forms were reviewed across 2014. There were two forms in use, one of which does not have a section to indicate if family are notified (link evidence 1.1.9), and two forms did not have registered nurse sign out.

Finding:

18 incident forms were reviewed across 2014. There were two forms in use, one of which does not have a section to indicate if family are notified (link evidence 1.1.9), and two forms did not have registered nurse sign out.

Corrective Action:

There is one incident form used to report resident incidents – preferably including family notification – and all reported incidents are reviewed and signed off by the registered nurse.

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 human resources policies to support recruitment practices. The registered nurses practising certificate is on file. Seven staff files were reviewed (registered nurse – also the infection control and restraint coordinator, diversional therapist, cook, and four home assistants – all work in the dementia unit) and all had relevant documentation relating to employment. Performance appraisals are current in files reviewed.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed (two caregivers, one diversional therapist, registered nurse) were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is a two yearly education plan that includes all required sessions as part of these standards. Infection control training was scheduled to be delivered in June, however this did not occur (advised Infection control training was purposely postponed due to gastro bug and R/N was off with medical certificate). There were two findings from the certification audit relating to infection control training reported against 3.4.3 and 3.4.4, and improvement continues to be required. As this is a recurring matter, and the service has recently experienced a gastro infection affecting residents and staff, the risk rating against this finding is considered to be moderate. Due to the streamlined audit process currently in place, these findings are reported against this standard.

There is evidence of other scheduled training occurring and individual records are maintained for staff, this finding from the certification audit is now met. Interview with two caregivers confirm in-service training is being provided. Medication competencies are in completed annually for caregivers and enrolled nurse (and the registered nurse) who

are administering medication (sighted).

There is a staff member with a current first aid certificate on every shift.

E4.5f: There are 10 caregivers who work in the dementia unit, seven have completed the required dementia standards, and three are awaiting final sign off. There is a trained diversional therapist managing the activities programme.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: PA Moderate

Evidence:

There is a two yearly education plan that includes all required sessions as part of these standards. There is evidence scheduled training is occurring with the exception of infection control which was scheduled to be delivered in June. Individual records are maintained for staff, this finding from the certification audit is now met. Interview with two care givers confirm in-service training is being provided. Medication competencies are in completed annually for caregivers, and enrolled nurse (and the registered nurse) who are administering medication (sighted).

Finding:

The infection control coordinator (registered nurse) informed infection control training is provided at staff meetings (minutes recorded state hand washing discussed), however there is no evidence of content and evaluation – this was a finding from the previous certification audit. In addition infection control was scheduled to be delivered in June, however this did not occur (refer evidence 3.5). The infection control coordinator reported a staff questionnaire is completed, in the seven staff files reviewed there were four completed questionnaires dated 2012. As this is a recurring matter, and the service has recently experienced a gastro infection affecting residents and staff, the risk rating is considered to be moderate.

Corrective Action:

Deliver infection control training and evaluate its effectiveness

Timeframe (days): 30 (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 Low

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides coverage across both areas. Staffing is as follows: registered nurse 0800-1400 Monday through Friday, enrolled nurse 0600-1400 Monday through Friday, two caregivers in the morning (one in the dementia unit and one in the rest home), three during the afternoon (two full shift and one 1600-2100) and two on night shift (one in each area). The manager works full time. Both the manager and registered nurse are on call afterhours. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.

In the weekend there are only two caregivers on in the morning shift. It was noted #2.2.3.2 that a lap belt is used for the safety of a resident when staff are busy. An improvement is required to review staffing to align with E4.5 and to ensure residents can be safely supervised

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 Low

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides across both areas. Staffing is as follows: registered nurse 0800-1400 Monday through Friday, enrolled nurse 0600-1400 Monday through Friday, two caregivers in the morning (one in the dementia unit and one in the rest home), three during the afternoon (two full shift and one 1600-2100) and two on night shift (one in each area). The manager works full time. Both the manager and registered nurse are on call afterhours. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times..

Finding:

In the weekend there are only two caregivers on in the morning shift. It was noted #2.2.3.2 that a lapbelt is used for the safety of a resident when staff are busy.

Corrective Action:

Ensure staffing in the dementia unit is reviewed to align with ARC E4.5 and to ensure residents can be safely supervised

Timeframe (days): 90 (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: PA Low

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. In five (of five) files reviewed staff are not recording the time of entry, or designation in the notes and this is an area of improvement. Policies contain service name.

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: PA Low

Evidence:

All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Entries are legible, dated and signed by the relevant home assistant or registered nurse.

Finding:

In the five files reviewed staff use 'am', 'pm' to record time of entry, and designation is inconsistently recorded.

Corrective Action:

Record the time of entry and designation in the resident progress notes

Timeframe (days): 90 (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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

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

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

Attainment and Risk: FA

Evidence:

There is a policy and process that describe resident's admission and assessment procedures. Each resident has an InterRAI assessment conducted by the NASC and the registered nurse (RN) is in the process of reassessing residents using the InterRAI tool. Staff provide care according to the residents identified needs (confirmed by observation and by interview with the registered nurse, two caregivers - who work in both the rest home and dementia unit - two rest home residents and two family members - one rest home and one dementia unit resident).

D 3,1c: Services are provided by a multidisciplinary team which includes the RN, the EN and the GP who services all residents who live at the facility.

D16.2, 3, and 4: The RN undertakes the initial assessment and documents the initial care plan within 24 hours of admission, usually at the time of admission. Within three weeks and following further assessment, the resident centred care plan is developed by the RN (confirmed in review of five clinical records i.e., two rest home and three dementia unit residents).

D16.5e: Medical assessments are completed within 48 hours of admission by the GP and documented (confirmed in review of five clinical records (two rest home and three dementia unit)).

Residents may choose to retain their own GP or change to the facility GP who is contracted to provide medical services to residents. All residents choose to use the facility GP. The GP visits the home weekly and examines the residents at least three monthly. Generally he sees everyone monthly and reviews their medicines. The GP visits are written in the medical notes. The GP confirmed during interview that he is notified promptly if there are any changes in resident health status. He has been the home GP for some years and states the communication is good and he has confidence in the RN's decision making.

A recreational assessment and activities care plan is completed over the first three weeks of the resident's admission by a diversional therapist.

A range of assessment tools completed on admission (as applicable) and reviewed at least six monthly include: a) dietary requirements, b) continence assessment, c) falls risk and mobility assessment, d) cultural needs assessment, e) skin assessment, and f) mental health. The residents are assessed for pain as part of their InterRAI assessment and reassessed for pain if in pain on admission. Resident centred care plans are used by the caregivers to ensure care delivery is in line with the residents' assessed needs (with the exception of the unauthorised use of restraint (link 2.2.3)).

D 9.2: There is a verbal handover and a written handover between shifts of caregivers which is available to all staff. The handover is based on the handover records which are documented in a book. The handover book is kept in the nurses' station. Verbal handovers occur for oncoming staff and cover resident significant events, changes to care, GP visits, infections, incidents and any medication changes.

Residents' files include; RN initial assessment, long term resident centred care plans, short term (acute) care plans, medical notes, evaluations, BP and weight recordings, laboratory results, consents, advance directives, letters, referrals.

Tracer Methodology:

Rest home resident:

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

Dementia unit resident

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The service provides care for residents requiring rest home level care and dementia care. Individualised care plans are in use from the day of admission. When a resident's condition alters, the RN initiates a medical review and notifies the GP of the need to visit and will notify relatives (confirmed in discussions with the registered nurse, and by discussion with two of two rest home residents and two of two family members (i.e., one rest home and one dementia unit resident).

Wound care assessment and progress notes are in place (sighted). There is one resident with multiple skin wounds XXXXXXXX documented in progress notes. All wound care is managed by the EN under supervision of the RN. Continence products are available (sighted) and resident files include a urinary continence assessment, bowel management and bowel chart. Specialist continence advice is available as needed and the RN can describe the referral process.

There is a falls risk policy in place. Falls risk and mobility assessments are completed on admission and reviewed earlier if there are changes to a resident's mobility status. Falls are required to be recorded on an incident/accident form. One resident was noted to have fallen on several occasions and the falls were not documented in his progress notes and the corresponding incident/accident forms were not able to be evidenced (link 1.2.4.3).

There is a policy on challenging behaviours and de-escalation techniques with behaviour charts available for use as needed. All residents who exhibit significant behaviours that challenge are being cared for in the dementia unit.

Palliative care is able to be delivered with support from local hospice staff.

There are a number of monitoring tools in use which are used intermittently as necessary. Staff monitor residents' blood pressures, weights, food intake, fluid balance status and blood sugar levels.

The RN and caregivers have access to equipment to provide care which includes but is not limited to: thermometers, a stethoscope, BP monitoring equipment, floor standing weighing scales, pressure relieving resources, shower stools/chairs, walking frames, wheelchairs, and resident transferring aids (one hoist) - confirmed by observation and discussion with the registered nurse and two of two caregivers who work in both the rest home and dementia unit.

D15.3: This audit identified that an improvement is required regarding the provision of equipment (sitting scales), as there are four residents who are not able to stand unaided on the floor scales and therefore are not able to be weighed (refer evidence 1.3.3) and this is an area of improvement.

D16.1a & 1b.i: New residents are welcomed, orientated, and encouraged to adapt to their new residence.

D16.5a: Routines in use in the facility reflect community norms and practices. (observed and confirmed in discussions with three rest home residents and two of two family members (one rest home resident and one dementia unit resident). Much of the routine focuses around the food service and the activities programme.

D18.3 and 4: Dressing supplies are available and there are adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment available (confirmed in discussions with the RN).

E 4.3 Each care plan in the dementia unit contains a description of the residents current abilities, level of independence, identified needs/deficits, takes account of habits, routines idiosyncrasies and specific behavioural management strategies, contains strategies for minimising challenging behaviours over the 24 hours.

E4.4: Support is individualised for residents living in the dementia unit and includes provision to ensure that their behaviours are managed appropriately.

Residents are satisfied with the services they receive (confirmed in discussions with three rest home residents and two of two family members (one rest home, one dementia unit).

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

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

Attainment and Risk: PA Moderate

Evidence:

There are four residents who are not able to stand unaided on the current floor weighing scales. The service does not have access to sitting scales and therefore these residents cannot be weighed (reference ARC D15.3).

Finding:

Staff cannot access sitting scales to weigh residents who are unable to stand unaided on the existing floor scales.

Corrective Action:

Ensure there is sufficient equipment to meet the needs of residents (ARC D15.3).

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The activities programme provided at the facility is overseen by two diversional therapists who job share (both interviewed). One person works 8.30 to 4.30 four days a week Mondays to Thursdays and the other works Mondays and Fridays. Therefore on Mondays both diversional therapists are on duty. The same day activities programme is used for both the rest home and the dementia unit. Group activities are commenced in the dementia unit lounge and then offered to the residents who live in the rest home area in their lounge. When there are external entertainers on site this activity is typically offered to dementia residents in their lounge because it is bigger and staff report the rest home residents will usually choose to attend the dementia unit programme.

Each resident has an individual and group programme of activities (confirmed in review of five of five clinical records (two rest home and three dementia) and in discussions with three of three rest home residents and two of two family members (one rest home and one dementia). Residents in both the rest home and dementia unit choose to participate in the group programme. The group programme includes physical activities (e.g., exercises, walks, balloon volley ball, golf putting, individual hand massages); mental stimulation (e.g., newspaper reading, bingo, quizzes, sing-alongs, card games); and social stimulation (e.g., the hairdresser, van trips to go shopping (rest home residents) or just for a drive (dementia unit residents) and external entertainers (dementia programme only).

Some rest home residents are quite independent and as such enjoy their own social life. Some residents choose to follow their independent programme.

D16.5 c iii: This audit identified that although each subsidised resident has a written and implemented activities programme, which is reviewed six monthly, the activities plan is not reviewed at the same time as their care plan is reviewed and this is an area of improvement.

D16.5d: The activities programme includes group and individual activities and involvement with the wider community. The diversional therapists record the activities plan in a diary (e.g., when external entertainers attend). On Monday mornings the therapists decide the group activities plan for the week and they write it down on a Recreational activities sheet which they destroy once they have provided the programme (last records sighted were May 19). Attendance at group activities is recorded in the resident's progress notes.

Residents are satisfied with their individual and group activities programmes (interview three of three rest home residents and two of two family members (one rest home resident and one dementia unit resident)).

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

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

Attainment and Risk: PA Low

Evidence:

D16.5 c iii: This audit identified an improvement also required around the review of the individual activities plans. Although each subsidised resident has a written and implemented activities programme, which is reviewed 6 monthly, these activities plans are not reviewed at the same time as the care plans are reviewed, which is not consistent with the intention of a multidisciplinary review of care.

Finding:

Individual activities plans are not reviewed at the same time as the resident's plan of care is reviewed.

Corrective Action:

Ensure that the individual activities programme for each resident is reviewed at the same time as their plan of care is reviewed (ARC D16.5ciii).

Timeframe (days): 30 (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:**

Resident centred care plan evaluations are up to date. Six monthly evaluations or earlier occur if there are resident health changes. The evaluations are completed by the RN with input from the GP, caregivers, the resident and family if available, and any other relevant person or allied health professional involved in the care of the resident. The diversional therapists are conducting a separate review (link 1.3.7). All residents are in the process of having an InterRAI assessment completed by the RN.

A written evaluation is completed against the long term care plan's desired goals and progress/achievement towards the goals are recorded. Short term care plans are used and evaluated, resolved or added to the long term lifestyle care plan if the problem is on-going. Short term care plans are used for acute problems (e.g.: behaviours).

D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

D 16.2 d: All care plans are reviewed by the RN and amended where necessary to address current needs

D16.4a: Care plans are evaluated six monthly or more frequently when clinically indicated.

Residents and family are involved in evaluating the resident's care (confirmed in discussions with the RN, three rest home residents and two of two family members (one rest home resident and one dementia unit resident) and confirmed in review of five clinical records (three dementia unit residents and two rest home 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 1.3.12: 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 Low

Evidence:

There are policies and procedures in place to guide staff on medicines management that align with accepted guidelines. All medicines are charted by the residents' GP (confirmed in review of ten of ten medicine charts (seven dementia residents and three rest home residents). The findings from previous audits relating to a lockable mobile (medication) cabinet, signing (administration by one caregiver) of controlled drugs and controlled drugs not stored in a container fixed to drug cabinet have now been addressed.

Weekly checking of controlled drugs, identified at the previous audit remains a required improvement from the previous audit. There is evidence of fortnightly checks of the controlled drugs carried out by the RN rather than weekly checks, as is required. The audit identified an improvement also required around standing orders which are in place, although the RN states they are not used in practice. The orders do not comply with the guidelines published in 2012 by the Ministry of Health. The RN and the GP intend to discontinue the orders and go back to individual prescribing.

Tablets are packaged using the Douglas system. Non-tablet medicines are supplied in pharmacy labelled containers. The service uses one pharmacy to supply all medicines. Medicines are administered by caregivers on each shift or the RN or the EN (observed during a medicine round and confirmed in discussion with the RN and two of two caregivers who work in both the rest home and dementia unit). Their competency to administer medicines is assessed by the RN who has been assessed as competent by another RN who is employed at the DHB. Caregivers fill out a competency assessment and undertake supervised medication rounds by the RN before being deemed competent. Staff have access to online medicines information from MedSafe. No residents self-administer medicines. The GP conducts reviews of residents three

monthly for stable residents and more frequently if the resident is unwell. The RN has a system in place to ensure compliance is maintained. The main medicines cupboard is a lockable cupboard. Medicines requiring refrigeration are stored in refrigerator in the medicines room. Controlled drugs are individually prescribed and packaged and stored in a locked metal container that is secured in a locked cupboard, in a locked medicines room. Two competent staff members check out the controlled drugs. The RN comes on site to administer sub cut controlled drugs. Syringe pumps of controlled drugs are organised by the hospice as needed. A six monthly pharmacy audit is completed. Staff sign for the administration of controlled drugs. Medicines no longer required are quarantined and returned to the pharmacist. Medicine reconciliation occurs. All medicines received are checked by the RN or a senior staff member on arrival. Any discrepancies would be documented and the error fed back to the pharmacy (there have been no discrepancies noted since the previous audit). Staff sign the administration charts and then initial once they have administered a medicine to a resident.

Ten of ten medicine charts sampled have photo identification, allergies/adverse reactions noted and any special instructions for administration on the medicines chart. The GP prescribing meets legislative requirements. The signing sheet is correctly signed and prn medications are correctly charted, dated and timed on administration.

D16.5: All ten of ten medicine charts sampled identified that the GP had seen and reviewed the resident three monthly and the medicine chart was signed accordingly.

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 Low

Evidence:

The controlled drugs register shows that controlled drugs are being checked fortnightly by the registered nurse rather than weekly. This remains an improvement from the previous audit. This audit further identified that standing orders for medicines do not comply with the Ministry of Health Guidelines published 2012. The RN and the GP intend to discontinue the practice of standing orders and return to individual prescribing.

Finding:

Controlled drugs are not being checked weekly, which remains an improvement from the previous audit, and standing orders for medicines do not comply with the guidelines published by the Ministry of Health 2012, which is a new identified improvement.

Corrective Action:

Ensure controlled drugs are checked weekly and the practice of standing orders complies with the guidelines published in 2012 by the Ministry of Health.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Policies and procedures are in place for food management. Meals are based on a four week cycle and the kitchen is staffed by a cook Monday to Friday and a weekend cook (both cooks interviewed). There is a kitchen hand on duty each day and there is a weekend cook. Night shift prepare the breakfast and the cook prepares the main meal and the evening meal. The main meal is served at lunchtime. Modified equipment is available. Snacks and hot drinks are available between meals.

Improvements continue to be required around food temperature monitoring. The service purchased a temperature probe for monitoring food temperatures and the cook and RN assured the auditors that monitoring using the probe occurs. However temperature records have not been documented.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Food temperatures are not recorded, although staff report that food temperature monitoring is occurring prior to serving hot food to residents.

Finding:

Food temperatures are taken with a probe but not recorded and therefore could not be evidenced.

Corrective Action:

Develop and implement a system of food temperature monitoring.

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 1.4.2: 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:

There is a current building warrant of fitness which expires 22 June 2015. The service has addressed the shortfall identified at the previous certification audit which involved servicing of the hoist and monitoring of hot water temperatures. The hoist is now due for its annual servicing on 7 February 2015. Further improvements continue to be required around the calibration of floor weighing scales.

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 Moderate

Evidence:

There is no evidence that the floor scales using for recording residents weights have been calibrated by an external provider with expertise in calibration techniques, which has relevance for clinical decision making.

Finding:

The floor scales in use have not been calibrated by an external provider with expertise in calibration techniques. This remains an improvement from the previous audit.

Corrective Action:

Ensure the floor scales are calibrated by an expert.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Springvale has policies and procedures on restraint minimisation and safe practice. The registered nurse 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 resident assessed as requiring restraint (lap belt). There are procedures for restraint if it should be required and associated documentation to support the policy (link 2.2.3). Restraint is included in the monthly staff meeting. Restraint education is provided annually and was last provided for staff in April 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.3: 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 service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There is an approved restraint for a lap belt. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Restraint authorisation is in consultation with the resident (as appropriate) and/or family. Restraint use is discussed at the monthly staff meetings. The restraint coordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident, however this was not seen to be evident for the resident using a lap belt and this is a required improvement. A restraint register is in place. This audit also identified an unauthorised restraint (i.e., bedrails) being used for one resident in the dementia unit and this is also an area for improvement.

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 Moderate

Evidence:

This audit identified an improvement in that an unauthorised restraint (i.e., bedrails) was in use for one resident living in the dementia unit. Reportedly bed rails are used when the service is busy so the resident does not fall out of bed. The RN reported that the resident's family will also apply the restraint. The RN does not support the use of the restraint for this resident due to the risk of the resident harming herself on the bed rail. The resident is nursed on a hospital bed that has bed rails attached, making it easy

for staff and relatives to apply. The RN believes the resident is appropriately assessed by the needs assessment and coordination agency and would not meet the criteria for a reclassification to hospital level residential care.

The audit also identified a further improvement that monitoring documentation for another resident living in the dementia unit who is restrained intermittently with a lap belt to prevent him from falling was incomplete as it did not document duration of the restraint on every occasion.

Finding:

An unauthorised restraint was observed in the form of a bedrail for a resident living in the dementia unit to prevent her falling out of bed when caregivers were busy, and monitoring documentation for another resident living in the dementia unit was incomplete.

Corrective Action:

Ensure care staff do not practice unauthorised restraint and ensure restraint documentation is complete for the duration of intermittent restraints.

Timeframe (days): 30 (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.)*

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (registered nurse) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is reported at the staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

In June (2014) a gastro infection affected residents and staff at the facility, the infection was managed and contained, individual infection reports documented. An overview follows:

The first resident exhibiting vomiting was reported 17 June and by 20 June there were total five residents who had/were exhibiting symptoms. All residents were isolated in their rooms and standard precautions instigated. Public Health were notified and informed current processes appropriate. Visitors had been asked not to visit during this time (between 19 June and 1 July). Visiting being reinstated 1 July. The infection was contained, and did not spread into the rest home wing. There were four staff affected during this period, and as a result unaffected staff worked longer (than usual) shifts.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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