Presbyterian Support Southland - Peacehaven

Current Status: 6 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

Peacehaven is part of the Presbyterian Support Southland Group. Peacehaven provides care across four service levels including; rest home, hospital, and dementia and psychogeriatric level care (the dementia units are named Iona). The facility can provide care for up to 121 residents. On the day of audit there were 20 rest home and 58 hospital level residents; 17 residents in the dementia wing and 12 residents in the psychogeriatric wing.

At the time of audit the service is being overseen by the Presbyterian Support Southland Director of Services for Older Persons who is an experienced registered nurse. There are two clinical coordinators (both registered nurses) who support the clinical areas. Non-clinical matters are being supported by an administrator. A new manager has been appointed and will start 8 September 2014.

This audit has identified improvements required around complaints management, meeting minutes, incident reporting, aspects of wound management, pain management, management of weight loss, documentation of interventions to reflect the resident's current health status, checking of medications on delivery, call bell response time and restraint and enabler documentation.

Audit Summary as at 6 August 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 6 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.

Organisational Management as at 6 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 low risk.

Continuum of Service Delivery as at 6 August 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

Safe and Appropriate Environment as at 6 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 low risk.

Restraint Minimisation and Safe Practice as at 6 August 2014

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

Infection Prevention and Control as at 6 August 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Audit Results as at 6 August 2014

Consumer Rights

Peacehaven/Iona provides care in a way that focuses on the individual resident. There is a Maori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. A two yearly staff training programme supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are in place and documented. Residents and family interviewed verified on-going involvement with community. There is improvement required around complaints management.

Organisational Management

Peacehaven/Iona is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at quarterly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around meeting minutes and incident reporting.

Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents confirmed the admission process and the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. Nursing assessments and

support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The residents' needs, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the six monthly reviews. There is an improvement required around aspects of wound management, pain management, management of weight loss and documentation of interventions to reflect the resident's current health status. Resident files are integrated and include notes by the general practitioner (GP), physiotherapist, dietitian, nurse practitioners and other allied health professionals.

The activity programme is resident focused and provides group and individual planned activities such as baking, crafts, board games, entertainment, outings and drives to meet the physical, emotional, cultural, spiritual and cognitive abilities of the consumer group. There are volunteers involved in the service and community links are maintained.

Education and medicines competencies are completed by all staff responsible for administration of medicines. There is an improvement required around the checking of medications on delivery. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

Safe and Appropriate Environment

The facility is purpose built and building and plant comply with legislation. There is a preventative maintenance programme being implemented. The secure unit includes adequate space and courtyards which are safe and secure with well maintains paths, seating and an edible garden. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. The lounge areas are spacious with furniture appropriate for residents. The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. Emergency procedures and first aid is included in the training programme, and there is a first aid qualified member of staff on each shift. There is a civil defence kits to accommodate the facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms. Improvement is required around call bells.

Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice manual with associated policies to support practice. The policy includes definitions of restraint and enablers that is congruent with the definition in standard. The service has a restraint co-ordinator who is the physiotherapist and a job description is available. The service has a restraint register which includes the type of restraint, date commenced and comments. Restraint in service and competencies have been

completed. Improvements are required in relation to documentation of risks associated with enablers and restraints and evaluation of restraints.

Infection Prevention and Control

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

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Presbyterian Support Southland
Certificate name:	Presbyterian Support Southland - Peacehaven

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit
Premises audited:	Peacehaven Village
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	**Start date:** 6 August 2014 **End date:** 7 August 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	107

Audit Team

Lead Auditor	XXXXX	**Hours on site**	17	**Hours off site**	6
Other Auditors	XXXXX	**Total hours on site**	34	**Total hours off site**	14
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2.5

Sample Totals

Total audit hours on site	51	Total audit hours off site	22.5	Total audit hours	73.5

Number of residents interviewed	6	Number of staff interviewed	28	Number of managers interviewed	5
Number of residents' records reviewed	11	Number of staff records reviewed	9	Total number of managers (headcount)	5
Number of medication records reviewed	22	Total number of staff (headcount)	168	Number of relatives interviewed	14
Number of residents' records reviewed using tracer methodology	4			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Monday, 8 September 2014

Executive Summary of Audit

General Overview

Peacehaven is part of the Presbyterian Support Southland (PSS) Group. Peacehaven provides care across four service levels including; rest home, hospital, and dementia and psychogeriatric level care (the dementia units are named Iona). The facility can provide care for up to 121 residents. On the day of audit there were 20 rest home and 58 hospital level residents; 17 residents in the dementia wing and 12 residents in the psychogeriatric wing. At the time of audit there were reportedly no residents under the medical component of their certificate.

At the time of audit the service is being overseen by the Director of Services for Older People (DSOP) who is an experienced registered nurse. There are two clinical coordinators (both registered nurses) who support the clinical areas. Non-clinical matters are being supported by an administrator. A new manager has been appointed and will start 8 September 2014.

This audit has identified improvements required around complaints management, meeting minutes, incident reporting, aspects of wound management, pain management, management of weight loss, documentation of interventions to reflect the resident's current health status, checking of medications on delivery, call bell response time and restraint and enabler documentation.

Outcome 1.1: Consumer Rights

Peacehaven/Iona provides care in a way that focuses on the individual resident. There is a Maori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. A two yearly staff training programme supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are in place and documented. Residents and family interviewed verified on-going involvement with community. There is improvement required around complaints management.

Outcome 1.2: Organisational Management

Peacehaven/Iona is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at quarterly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around meeting minutes and incident reporting.

Outcome 1.3: Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents confirmed the admission process and the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. Nursing assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.
The residents' needs, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the six monthly reviews. There is an improvement required around aspects of wound management, pain management, management of weight loss and documentation of interventions to reflect the resident's current health status. Resident files are integrated and include notes by the general practitioner (GP), physiotherapist, dietitian, nurse practitioners and other allied health professionals.
The activity programme is resident focused and provides group and individual planned activities such as baking, crafts, board games, entertainment, outings and drives to meet the physical, emotional, cultural, spiritual and cognitive abilities of the consumer group. There are volunteers involved in the service and community links are maintained.

Education and medicines competencies are completed by all staff responsible for administration of medicines. There is an improvement required around the checking of medications on delivery. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

Outcome 1.4: Safe and Appropriate Environment

The facility is purpose built and building and plant comply with legislation. There is a preventative maintenance programme being implemented. The secure unit includes adequate space and courtyards which are safe and secure with well maintains paths, seating and an edible garden. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. The lounge areas are spacious with furniture appropriate for residents. The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. Emergency procedures and first aid is included in the training programme, and there is a first aid qualified member of staff on each shift. There is a civil defence kits to accommodate the facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms. Improvement is required around call bells.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice manual with associated policies to support practice. The policy includes definitions of restraint and enablers that is congruent with the definition in standard. The service has a restraint co-ordinator who is the physiotherapist and a job description is available. The service has a restraint register which includes the type of restraint, date commenced and comments. Restraint in

service and competencies have been completed. Improvements are required in relation to documentation of risks associated with enablers and restraints and evaluation of restraints.

Outcome 3: Infection Prevention and Control

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

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	42	0	8	0	0	0
Criteria	0	92	0	9	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.1	The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with	PA Low	There are instances where responses to complainants report actions to be undertaken, but there is no evidence on file/records of this having occurred, examples follow.	a) Ensure agreed actions are recorded,	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		Right 10 of the Code.		a)Complaint (14 February 2014) response letter states follow-up at the February nurses meeting and care workers meeting, review of both meeting minutes does not record discussion of the complaint. b) Complaint (26 March 2014) meeting held with complainant minutes suggest further meeting in one months' time, there is no evidence of this having occurred in the complaints file. In addition a further complaint was received (30 June 2014) and the response noted there would be follow-up once meeting with involved staff had occurred. A meeting with the named staff member was being arranged for early July.		
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	There is one complaint (verbal) that has been responded to however do not appear on the rest home/hospital complaints register.	Ensure all complaints are recorded on the register	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 Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	a) Quality meeting minutes and monthly nurses meetings (combined Peacehaven/Iona) do not report incidents occurring in Iona. b) Nurses meeting (10 June 2014) reports: 'how often is the measuring of liquid morphine being carried out', this does not appear in the meeting 08 July 2014. c) Meeting minutes do not consistently report action taken/responsibility/by when – such as nurses meeting 10 June 2014 reported an increase in falls especially in Kalimos area, there is no reported action taken. Note: PSS are establishing a falls project across the	Ensure meeting minutes are an accurate reflection of the discussion/outcomes of the meetings, including follow up to actions taken as matters arising.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				services with two weekly reporting of falls. d) Resident and family meeting minutes do not always record follow up of issues at the subsequent meeting. Relative interviews reported inconsistent follow up of issues raised at family meetings.		
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	Four (of four) resident files were reviewed and the following was noted: a) File one – progress notes report XXXXX b) File two – progress notes report XXXX c) File three – progress notes report XXXXX d) File four – progress notes record challenging behaviour that is not recorded on either an incident form or a behaviour monitoring chart	Changes in resident health status are reported through the incident reporting process.	60
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	1) Wound assessment forms are incomplete for one dementia, one psychogeriatric, seven hospital and two residential wounds including date, type of wound, duration of wound and frequency of dressing. Six of 12 wounds in the hospital area did not have evaluations completed as per documented frequency. 2) There is no 15 minute documented monitoring in place as identified for hospital resident following wandering outside of facility as reported in progress notes. 3) The use of	1) Ensure wound assessment forms are completed and evaluations are completed as per documented frequency. 2) Ensure monitoring is in place for at risk resident of wandering. 3) Ensure pain assessments are completed for new, exacerbation of pain and	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				controlled drug pain management is not documented in the long term support plan or pain assessment for one PG resident. There are no pain assessments for three rest home residents who identify pain a) resident commenced on XXXXX and prn analgesia. There is no pain assessment for the same resident had a fall with injury requiring analgesia prescribed by the GP. b) Resident seen by GP for XXXXX was prescribed anti-inflammatory medication. The medication was not received from the pharmacy and had not been followed up (corrected on day of audit). There is no pain assessment or pain monitoring chart in place c) Resident with XXXXX has no pain assessment or pain monitoring chart in place. 4) a) Dementia care resident has lost 4.8kg over three months and a further XXXX in the last month. The long term support plan has not been updated to reflect the current weight loss. The MNA has not been reviewed and weekly weighs have not been implemented as per GP instructions May 2014. b) Hospital resident with increased wandering has had XXX weight loss over three months. There is no documented interventions, review of MNA or monitoring of food and fluid intake. 5) There has been no update to the support plan for hospital resident admitted to hospital with increased seizure activity.	chronic pain. Ensure residents receive analgesia as prescribed and pain monitoring charts are in place to monitor the effectiveness of pain relief. 4) Ensure weight loss interventions are documented, implemented ad monitored. 5) Ensure the resident support plan reflects the resident's current needs.	
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,	PA Low	There is no evidence of checking of medications on delivery against the medication chart.	Ensure medications are checked against the medication chart on delivery.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Low	Interview with the Director Services for Older People (DSOP) and the Quality Manager indicate an awareness of the feedback and report work is being undertaken to address the issues raised such as performance management of staff and on-going monitoring of call bell response (noted in internal audit data). During the audit a test of the call bell response time was conducted and there was no response from staff for over 15 minutes.	Ensure that all call bells are answered in a timely manner.	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	One resident's file reviewed did not show evidence that risks related to enabler use is documented in the residents support plan.	Ensure that all residents with enablers have risks identified related to enabler use and that these are documented in the residents support plan.	90
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 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	PA Low	Three files from four files reviewed do not show evidence that the resident's support plan reflects risk.	Ensure that all residents have documented risks related to use of restraint in the residents support plan.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		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.				

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 1.1.1: 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:

Peacehaven/Iona has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the in-service programme. Interview with eight care workers (six work in the rest home/hospital and two in the dementia units) demonstrate an understanding of the Code. Elder abuse training is included in the two-yearly compulsory study day. Residents interviewed (four rest home and two hospital) confirm staff respect privacy, and support residents in making choice where able.

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:

There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The resident meetings (minutes reviewed March and April 2014) also provide the opportunity for residents to raise issues. Residents interviewed (four rest home and two hospital) and relatives (ten hospital, one dementia and three psychogeriatric) inform information has been provided around the Code. The management team informs an open door policy for concerns or complaints.
D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission. The manager and registered nurses describe discussing the information pack with residents/relatives on admission.
D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect, which is included in the compulsory study days. A resident satisfaction survey is completed annually (December 2013). The December survey informed an overall satisfaction with the service as 92% for hospital residents and 80% for rest home residents. Hospital relative overall satisfaction was 92.7% and rest home relatives 90%.

Relative interviews (total 14) reported that while the food is good (or very good) (seven), there were areas of improvement including: personal cares for residents, 'growly' staff and timely call bell response (link 1.4.7). Interview with the Director Services for Older People (DSOP) and the quality manager indicate an awareness of the feedback and report work is being undertaken to address the issues raised such as performance management of staff and on-going monitoring of call bell response (noted in internal audit data) (link 1.4.7).

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. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with eight care workers (six work in the rest home/hospital and two in the dementia units) describe how choice is incorporated into resident cares. There is an abuse and neglect policy being implemented and staff attend a compulsory study day two yearly which includes education around abuse and neglect.
D4.1a Eleven resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.
D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality
D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

E4.1a Four family members from the dementia unit state their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

ARHSS D4.1b Two psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A3.2 Peacehaven/Iona has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.
D20.1i There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)
Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)
The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)
The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Residents interviewed (four rest home and two hospital) confirm that staff take into account their culture and values.
D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.
D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.

ARHSS D4.1d: Two psychogeriatric care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff meetings occur quarterly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with six registered nurses and two enrolled nurses confirm an awareness of professional boundaries. Interview with eight care workers (six work in the rest home/hospital and two in the dementia units) could discuss professional boundaries in respect of gifts.

ARHSS D16.5e: Interviews with two care workers who worked in the dementia unit could describe how they build a supportive relationship with each resident. Trust, security and self-esteem are built through looking after the same resident for a period of time.

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:

Peacehaven/Iona has a suite of appropriate policies and procedures that are updated as necessary. Presbyterian Support Southland participate in the QPS benchmarking programme so monitoring against clinical indicators can be undertaken against all sites. There is an active culture of on-going staff development with the Career force

programme being implemented. There is evidence of education being supported outside of the prescribed training plan such as advanced care plan training, wound care and outbreak management.

ARC A2.2 Services are provided at Peacehaven/Iona that adhere to the health & disability services standards.
ARC D1.3 all approved service standards are adhered to.
ARC D17.7c There are implemented competencies for care workers and registered/enrolled nurses including: medication and manual handling. RNs have access to external training.

ARHSSD17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication.

Residents interviewed (four rest home and two hospital) were generally positive about the care they receive (refer evidence 1.1.3). Interview with eight care workers (six work in the rest home/hospital and two in the dementia units) inform they are supported by the registered nurses (RN)'s and manager.

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: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed from June and July 2014 identify family were notified following a resident incident. Interview with eight care workers (six work in the rest home/hospital and two in the dementia units), two enrolled nurses and four registered nurses inform family are appropriately notified following a resident change in health status.

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 (ten hospital, one dementia and three psychogeriatric), interviewed stated that they are informed when their family member's health status changes or of any other issues arising.
D11.3 The information pack is available in large print and this can be read to residents.

ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. General informed consent obtained includes the following: collection, storage and release of information, photograph for display and identification purposes and transport and outings. The six RNs, two enrolled nurses and eight care workers (six rest home/hospital and two dementia/psychogeriatric) interviewed are knowledgeable in the informed consent process. All 11 resident files (four hospital, three rest home, two dementia care and two psychogeriatric) have either a resident initiated resuscitation form or a medically indicated not for resuscitation form. The GP signs to deem the resident competent or not competent. Where the resident is deemed incompetent there is evidence the GP discusses medical indications for or not for resuscitation with the enduring power of attorney (EPOA) or family. Advance care planning is evident in files of competent persons where appropriate. There is an advance care plan developed for the non-competent resident signed by the EPOA which is a guide for health care workers. The palliative nurse practitioner ensures discussions with the family and GP have taken place.

D13.1 there were 11 admission agreements sighted signed appropriately.
D3.1.d The service actively involves family as evidenced in decisions that affect their relative's lives.
Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with six RNs, two enrolled nurses and eight care workers (six rest home/hospital and two dementia/psychogeriatric) identify that consents are sought in the delivery of personal cares and this is confirmed by six residents interviewed (four rest home, two hospital).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)
The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)
Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)
Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

Attainment and Risk: FA

Evidence:

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interview with the management team confirms practice. Residents interviewed (four rest home and two hospital) confirm that they are aware of their right to access advocacy.
D4.1d; Residents interviewed (four rest home and two hospital) and relatives (ten hospital, one dementia and three psychogeriatric) identified that the service provides

opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy services
ARC D4.1e. The resident files include information on residents' family/whanau and chosen social networks.

ARHSS D4.1f: The two psychogeriatric resident files reviewed include information on resident's family/whanau and chosen social networks.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D3.1h: Residents interviewed (four rest home and two hospital) confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Interviews with residents (three rest home, one residential disability/hospital and four hospital) confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.
D3.1.e Discussion with eight care workers (six work in the rest home/hospital and two in the dementia units), the diversional therapist, and residents interviewed (four rest home and two hospital) and relatives (ten hospital, one dementia and three psychogeriatric) confirm residents are supported and encouraged to remain involved in the community and external groups.

ARHSS D16.5f: Discussion with four family members from the dementia service identified 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: PA Low

Evidence:

There is a complaints policy to guide practice. The clinical coordinator of the rest home/hospital and/or Iona leads the investigation and management of complaints (verbal and written) supported by the DSOP. There are two complaints (and compliments) log/registers that records activity for the rest home/hospital and Iona. Complaints are discussed at the monthly quality meeting (link 1.2.3). Complaints forms are visible at the entrance of the facility.

There are 16 recorded 2014 complaints for the rest home/hospital including two complaints that relate to call bell response, and six that report staff attitude as an issue (also refer evidence 1.1.3). There are eight recorded complaints on the Iona 2014 register. Complaints have been investigated and a response provided to the complainant in a timely manner. There are instances where responses to complainants report actions to be undertaken, but there is no evidence on file/records of this having occurred and this is an area of improvement. In addition there is one complaint (verbal) received that has not been included on the register and this is an area of improvement.

Residents interviewed (four rest home and two hospital) 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.

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

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: PA Low

Evidence:

There is a complaints register for the rest home/hospital and one for the dementia service (Iona). Verbal and written complaints are recorded included action, resolution and close out.

Finding:

There are instances where responses to complainants report actions to be undertaken, but there is no evidence on file/records of this having occurred, examples follow.

a)Complaint (14 February 2014) response letter states follow-up at the February nurses meeting and care workers meeting, review of both meeting minutes does not record discussion of the complaint.

b) Complaint (26 March 2014) meeting held with complainant minutes suggest further meeting in one months' time, there is no evidence of this having occurred in the complaints file. In addition a further complaint was received (30 June 2014) and the response noted there would be follow-up once meeting with involved staff had occurred. A meeting with the named staff member was being arranged for early July.

Corrective Action:

a) Ensure agreed actions are recorded,

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

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)
An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: PA Low

Evidence:

There is a complaints register for the rest home/hospital and one for the dementia service (Iona). Verbal and written complaints are recorded included action, resolution and close out.

Finding:

There is one complaint (verbal) that has been responded to however do not appear on the rest home/hospital complaints register.

Corrective Action:

Ensure all complaints are recorded on the register

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

Outcome 1.2: Organisational Management

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

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)
The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

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

Attainment and Risk: FA

Evidence:

Peacehaven/Iona provides care for up to 121 residents across four service types – rest home, hospital, dementia and psychogeriatric services. The total includes 4 double rooms, of which only one had two residents (married couple) in the room. There are therefore, three vacant beds (in the double rooms). On the day of audit there were 20 rest home residents and 58 hospital residents (including one respite). There are 20 dementia beds and 17 residents, and 20 psychogeriatric beds with 12 residents. The 81 beds in the rest home/hospital part of the service have reportedly been previously approved as dual purpose. While this is the case, the service attempts to have one dedicated rest home level wing and three hospital wings.

Peacehaven/Iona is part of the Presbyterian Support Southland group who has developed a charter that sets out its vision and values. There is a risk management plan for the PSS group (reviewed July 2014) and a Quality Improvement Plan (February 2014-July 2015). The quality improvement plan identifies goals such as developing career pathway for staff, further develop the QPS benchmarking programme and continue to developed advanced nursing roles.

Peacehaven/Iona (rest home and hospital) and Iona (dementia) both have an identified vision, values and goals 2014 year. Goals for both services include (but not limited to): reducing the number of complaints, 90% attainment on resident/relative satisfaction survey, and reduce the number of skin tears. Each goal has a critical success indicator, strategies to achieve and initiatives to be implemented.

An initiative in the process of being implemented is a falls minimisation project. At the time of audit, it was reported biweekly data was being collected across all PSS sites and a meeting to progress is planned for end August/September. This project aligns with the national falls strategy. There is an established and implemented quality programme that includes participation in the QPS benchmarking programme. Discussion about clinical indicators (eg. incident trends, infection rates), is included at the monthly quality meeting (link 1.2.3).

The previous manager left the service in December 2013 and the quality manager (experienced registered nurse) managed the facility for two months. At the time of audit the service is being overseen by the DSOP who is an experienced registered nurse. There are two clinical coordinators (both registered nurses) who support the clinical areas. The clinical coordinator of the rest home/hospital services has been in post since mid-2013, and was previously a registered nurse in the service for 9.5 years. The clinical coordinator in Iona (dementia) has been in post since February 2014 and has been a registered nurse in the service for approximately four years. Non-clinical matters are being supported by an administrator. A new manager has been appointed and will start 8 September 2014. The incumbent is a registered nurse with significant experience in managing aged residential care services. This is a new structure for the service – previously there was a manager in both Peacehaven/Iona (rest home/hospital) and Iona (dementia). Interview with the current management team report a goal is to continue to standardise and integrate systems across the two service areas. This is supported by both the DSOP and the quality manger (interviewed). There is a team of experienced registered nurses with aged residential care experience.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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:

During a temporary absence, a clinical coordinator (senior registered nurse) will cover the manager's role with support provided by the DSOP. The DSOP (who is providing management oversight) and the clinical coordinators (registered nurses) are experienced registered nurses.
D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

ARHSS D4.1a: The service operational plans, policies and procedures promotes a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.

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 Low

Evidence:

Peacehaven/Iona is implementing a quality and risk management system that includes participation in the QPS benchmarking programme which includes collection of data in regards to: infections(wound, skin and urinary), medication (staff responsibilities), care staff work hours, manual handling injuries, pressure sores, customer complaints, skin tears and resident falls(with and without injury). 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 the registered nurse guides for aged residential care to ensure best practice is being adhered to. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.

Quality matters are taken to the monthly quality meetings that comprise a core group of staff. Quality meeting minutes do not report incidents occurring in Iona. In addition the nurses meetings (combined Peacehaven/Iona) also do not discuss incidents occurring in Iona. There are instances where actions reported are not seen to have been followed up at the following meeting and also no reported action taken. These are areas of improvement. There is a quality manager (registered nurse) for the PSS group who has been with the service since November 2013. The quality manager supports Peacehaven/Iona in implementing the quality programme. 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.

Peacehaven/Iona infection control and health & safety committees both meet monthly. Infections (number and type) and health and safety matters – such as staff accidents - are discussed at the relevant meeting. Information is then taken to the quality meeting and feedback going to staff meetings (quarterly). Resident meeting minutes reviewed do not consistently report that issues raised are followed through. This is an area of improvement.

Peacehaven/Iona is implementing an internal audit programme that includes aspects of clinical care – such as file review. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective actions resulting from internal audit programme were recorded.

D19.3: There is an H&S and risk management programme in place including policies to guide practice. The administrator is the nominator health and safety coordinator for the facility who monitors staff accidents and incidents. She has attended relevant (stage 3) external training. There is a current hazard register in place.
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and a recent development of a project across the PSS group to focus on falls minimisation.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)
The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)
The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)
There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Peacehaven/Iona has a meeting schedule in place that is being implemented included monthly quality meetings, one-two monthly staff meetings and monthly infection control and health and safety meetings, and monthly nurses meetings. Meetings are minuted.

Finding:

a) Quality meeting minutes and monthly nurses meetings (combined Peacehaven/Iona) do not report incidents occurring in Iona.

b) Nurses meeting (10 June 2014) reports: 'how often is the measuring of liquid morphine being carried out', this does not appear in the meeting 08 July 2014.

c) Meeting minutes do not consistently report action taken/responsibility/by when – such as nurses meeting 10 June 2014 reported an increase in falls especially in Kalimos area, there is no reported action taken (etal). Note: PSS are establishing a falls project across the services with two weekly reporting of falls.

d) Resident and family meeting minutes do not always record follow up of issues at the subsequent meeting. Relative interviews reported inconsistent follow up of issues raised at family meetings.

Corrective Action:

Ensure meeting minutes are an accurate reflection of the discussion/outcomes of the meetings, including follow up to actions taken as matters arising.

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: FA

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 quality meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the manager for final sign off. Family are notified. 12 incident forms reviewed across June and July (a mix of rest home/hospital and dementia) indicate appropriate intervention has been undertaken. Four files were reviewed and there were three instances of broken skin reported in progress notes that did not have an associated incident form, and one around challenging behaviour. This is an area of improvement.

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. The service had three outbreaks of Norovirus in March, April and May 2014. The service reported each outbreak to organisational management and to Public Health South on the day that each outbreak started (12 March 2014, 6 April 2014 and 6 May 2014.

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 following an event. The resident is reviewed by the registered nurse at the time of event and the relevant section of the form completed. Family are seen to have been notified. Interview with the managed confirmed an awareness of resident incidents and resulting outcomes.

Finding:

Four (of four) resident files were reviewed and the following was noted:

a) File one – progress notes report XXXX

b) File two – progress notes report XXXX

c) File three – progress notes report XXXX

d) File four – progress notes record XXXX that is not recorded on either an incident form or a XXXX monitoring chart

Corrective Action:

Changes in resident health status are reported through the incident reporting process.

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: FA

Evidence:

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Nine staff files were reviewed (one clinical coordinator – who is also the restraint/infection control coordinator, one registered nurse; two care workers from both rest home/hospital and dementia, the administration who is the health & safety rep; chef, diversional therapist) and all had relevant documentation relating to employment. Of the files reviewed there was one performance appraisal overdue for review which has been scheduled. There is a process is in place to manage the appraisal process (including reminders from head office), this aspect of the standard is considered to have been met.

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 of newly appointed staff). Staff interviewed (eight care workers, two enrolled nurses and six registered nurses) were able to describe the orientation process and believed new staff were adequately orientated to the service.

PSS has a compulsory study day that includes all required education as part of these standards. Staff are required to attend a compulsory study day every two years. At the time of audit there were eight staff overdue to attend, letters to staff informing when they are scheduled to attend (up to the end of the year) were sighted and this aspect of the standard is therefore considered to be met. There is evidence that additional training opportunities are offered to staff such as attendance at wound care, advanced care planning and outbreak management. There is evidence on RN staff files of attendance at the RN training day/s and external training. Interview with eight care workers confirm participation in the career force training programme. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training.

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

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

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency

E4.5f There are 23 care workers in Iona, 14 have completed the required dementia standards, five care workers are in the process of completing and four have signed up and are due to start. Of those caregivers that are yet to start, none have commenced employment within the last 6 months.

ARHSS D17.1: The care workers in the dementia unit work across the psychogeriatric unit, and the data is the same as above

ARHSS D17.7 The diversional therapist working in the special care unit has completed ACE dementia modules

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows:

Rest home/hospital: clinical coordinator (Monday – Sunday) 0800-1700

AM: four RN/enrolled nurses(EN)s, 7 care workers 0700-1530; 6 care workers 0700-1330; 1 care worker 0700-1430

PM: three RN/EN, 7 care workers 1530-2300, 1 care worker1700-2100, 1 care worker 1600-2100

ND: one RN, 1 EN/senior care worker, 4 care workers

Iona (dementia/psychogeriatric): clinical coordinator (Monday-Friday) 0800-1700 & 1 RN 0900-1630 (Monday-Friday)

AM: one RN 0650-1520 Monday-Sunday, 4 care workers 0700-1500, 1 care worker 0700-0950 (there is capacity to increase 1 care worker 0800-1000 based on numbers)

PM: one RN 1510-2310 Monday-Sunday, 2 care workers 1500-2300, 2 care workers 1700-2100, 1 care worker 1330-2200, 1 care worker 1600-2400

ND: one RN 2300-0700, 1 care worker 2300-0700, 1 care worker 2400-0800.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 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. 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: FA

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:

Needs assessment service ensures all residents are assessed prior to entry. A placement authority form is sent to the receiving facility.
The manager and RN is responsible for the screening of residents to ensure entry has been approved. The potential resident and family are shown around the facility and are introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission.
The information pack includes all relevant aspects of service and associated information such as the H&D Code of Rights and how to access advocacy. There is an admission checklist in place and admission documentation which includes resident and next of kin details. The RN (interviewed) is able to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable time is arranged for admission. The Manager/RNs complete all the admission documentation and relevant notifications of entry to the service. Eleven signed admission agreement forms are sighted. Full documents are held at head office. Six residents (rest four home and two hospital) and relatives (ten hospital, one dementia care and three psychogeriatric care) interviewed state they received all relevant information prior or on admission. The GP is notified of a new admission.
D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract
D14.1 Exclusions from the service are included in the admission agreement.
D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement
E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy

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

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 an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. There are no declined entry records.

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: FA

Evidence:

The service provides rest home, hospital, dementia and psychogeriatric level of care for up to 117 residents.

D.16.2, 3, and 4: The 11 resident files sampled identifies the RN completes an initial nursing assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial nursing assessment and initial support care plan. Eleven resident files sampled identified that the long-term support plan is developed within three weeks. There is documented evidence of multidisciplinary reviews (MDT) held six monthly involving the resident/family/whanau, RN keyworker and primary care worker, activity team, general practitioner (GP) and where applicable allied health input such as the palliative or gerontology nurse practitioner. The RN amends the long term support plan to reflect on-going changes as part of the review process. Allied health professionals involved in the residents care are linked to the long term support care plan review such as, nurse practitioner, mental health community team, dietitian, physiotherapist and podiatrist.
All 11 resident files sampled included evidence of resident (as appropriate) and relative input into the initial nursing assessment and reviews.
D16.5e: Ten of 11 resident files sampled identified that the GP had seen the resident within two working days. One hospital resident had been transferred from hospital and was seen by the GP within five days of admission.

It was noted in 11 of 11 resident files sampled that the GP had examined the resident three monthly and carried out a medication review. One rest home and two hospital residents have not been at the service long for a three month review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status.

The GP (interviewed) is currently contracted to provide medical services for the residents at the facility. There are six GPs within the practice and locum cover is provided in his absence. He visits three times a week to see residents of concern and conduct three monthly reviews. He is available to meet with families on request or to discuss treatment options and resident health changes. The GP is available at other times to see residents on RN request. There is communication and liaison with the nurse

practitioner who is able to reviews residents and initiate investigations. There is an after-hours clinic or the emergency department for more urgent attention. The GP is complimentary about the care the residents receive and the medimap medication system.

ARHSS D16.6; Two of two resident files sampled with behaviours that challenge were reviewed from the psychogeriatric unit. Behaviours in both files are well identified through the assessment process, interventions and management plans incorporated into the long term support plan and behaviour monitoring for acute/escalating episodes of behaviour with evidence of regular evaluations, GP and nurse practitioner and mental health team involvement.

There is a verbal and written handover period between the shifts for all services that ensures staff are kept informed of resident's health status and any significant events. Progress notes are maintained each shift that record the residents cares and any significant changes to care, accidents/incidents, skin integrity, food and fluid intake etc.

There is a contracted physiotherapist 32 hours a fortnight to conduct initial resident physiotherapy assessments, follow-up resident referrals and post falls incidents and exercise programme. The physio assistant is employed for 20 hours a week Monday to Friday to assist the physiotherapist in implementing aspects of the physiotherapy programme including assisted walks and exercise programmes. Plan and evaluation of care progress notes are maintained in the integrated resident file. The podiatrist is contracted for four weekly visits for all diabetic residents and other residents by arrangement. The dietitian visits the service four weekly.

The nurse practitioner (NP) for older person's health (interviewed) is jointly funded by the district health board (DHB) and PSS. She is an experienced RN with 15 years aged care experience, three years with the DHB, master's degree and has been in the current role for one year. She liaises closely with the GPs and clinical co-ordinators attending the multidisciplinary meetings (MDT) and meeting with staff offering education and support and provides consultation in regards to policies and procedures. The NP is involved in quality projects with PSS such as the reduction of antipsychotics and advance care planning. The NP has examination and prescribing rights. She is based at the DHB rehabilitation unit and meets weekly with the two geriatricians at the rehabilitation service. .

PSS employ a palliative care nurse practitioner and records of visits are maintained in the resident file.

Eleven resident files sampled are as follows: Three rest home files: Four hospital files: Two dementia care files: Two psychogeriatric care files:

Tracer methodology; Rest home resident

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

Tracer methodology; Hospital resident

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

Tracer methodology: Dementia care resident

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

Tracer methodology: Psychogeriatric 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 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

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

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

Attainment and Risk: FA

Evidence:

Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial nursing assessment, first support plan and long term support care plan within the required timeframes. All 11 (three rest home, four hospital, two dementia care and two psychogeriatric) resident files sampled evidenced an initial nursing assessment and support care plan with reference to the information gathered on admission. Residents (four rest home and two hospital) advised on interview that assessments were completed in the privacy of their single room.
A range of assessment tools is completed on admission if applicable including (but not limited to); a) nutritional and fluid assessment b) falls risk c) moving and handling assessment. d) Braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment g) wound assessment h) skin assessment i) initial physiotherapy assessment.

ARHSS D16.5gii Two resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4, 2a Two resident files reviewed identified challenging behaviours assessments are completed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An initial nursing assessment forms the basis of an initial support plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care as follows: hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest and sleep, communication, behaviour and mood spirituality/faith and culture, medical needs. There is documented evidence of resident/relative/whanau involvement in the initial nursing assessment and support care planning process. The service are introducing advanced care planning as sighted in three hospital, one dementia and two psychogeriatric files reviewed. The palliative nurse practitioner completes the advance care plan in consultation with the resident or family wishes in regards to end of life care including cultural and spiritual needs and this is reviewed at regular intervals. The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance, food charts and other interventions), incident/accident and infection events summary and correspondence.
Short term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short term care plans are pre-printed for infections, nutritional needs and wounds.
Medical GP notes and allied health professional progress notes are evident in the 11 residents integrated files sampled. Residents interviewed are positive and complimentary about the staff, clinical and medical care provided.

D16.3k, ARHSS 16.3g: Short term care plans are in use for changes in health status.
D16.3f; ARHSS D16.5f Eleven out of 11 resident files reviewed (three rest home, four hospital, two dementia care and two psychogeriatric) identified that family have been involved in the support plan process.

ARHSS 16.3g: Two psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Both residents had comprehensive behaviour management plans.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Four rest home residents and two hospital resident interviewed state their needs are being met. Relatives interviewed (10 hospital, one dementia care and three psychogeriatric) stated the needs of their relative is being met.

D18.3 and 4 Dressing supplies are available and the treatment rooms are well stocked. All staff report that there are adequate continence supplies and dressing supplies. The district health board wound assessment form being used includes contributing health factors, length of time wound present, any infection /systemic infection, location and size of wound. There is a new order form for treatments and wound progress notes maintained. Short term care plans are in place for skin tears. Chronic wounds are inked to the long term support plan. There is an improvement required around wound management documentation and evaluations. There is evidence of the wound service and wound care nurse specialist involved in wound care. Pressure area risk assessments are completed on admission and reviewed six monthly or earlier as required. There is one pressure ulcer of the heel in the residential area, five wounds in the hospital area, two wounds and pressure injury of heel (one resident) in the psychogeriatric unit. There are two skin tears, no pressure areas or wounds in the dementia care unit. Pressure area interventions documented in care plans include the use of roho cushions, air

alternating mattresses and two hourly turns documented on turning/ position charts. All hospital level beds have pressure area grade mattresses. The wound nurse visits the service two to three weekly and oversees chronic wounds and wounds of concern. The wound clinic at the DHB is open to the RNs to attend and on-line training is also available.

Continence products are available and resident files include a urinary continence assessment, bowel management, wounds and continence products identified for day use, night use, and other management. An enrolled nurse has taken on the role of ensuring incontinence products are available, allocations are correct and provide advice and support on incontinence to staff. The EN is scheduled to attend training with the product representative Specialist continence advice is available as needed through the DHB and the continence product representative.

Behaviour management is described in the long term support plan as behaviour exhibited, management and interventions. The plan is reviewed by the multidisciplinary team six monthly. Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The gerontology nurse practitioner liaises with the GP and is readily available for advice, resources and education and initiates referrals to the mental health services for the older person as required. There is an improvement required around implementing monitoring for at risk residents.

A verbal pain inventory is completed for residents on regular or prn pain relief. Pain assessments include non pharmalogical strategies. Pain assessments are reviewed every six months and initiated for new or exacerbation of chronic pain. Pain monitoring charts are used to completed pre and post analgesia. Abbey pain scales are used for residents unable to verbalise pain. There is an improvement required around pain management.

The contracted physiotherapist completes resident mobility assessments and reviews six monthly. The physiotherapist is involved in post falls assessments, exercise programmes and staff education. Falls prevention strategies include review of falls risk assessments including the completion of a falls risk algorithm, use of sensor mats, physiotherapy reviews, good fitting footwear, mobility aids, ensuring the call bell is within reach and the environment is clutter free.

Residents weights are recorded on the initial nursing assessment on admission and recorded monthly thereafter on the monthly weight chart. The dietitian visits the service to review residents. Mini nutritional assessments (MNA) are completed identifying residents at risk. There is an improvement required around weight loss management.

ARHSS D16.4; There is good specialist input into residents in the psychogeriatric (PG) a unit. The gerontology nurse practitioner meets monthly with the Southland mental health services for the older person nurse practitioner who liaises with the psychiatrist as required. The clinical co-ordinator states the mental health services respond to referrals by phone call within 24-48 hours and will visit depending on the urgency and if non-urgent visit the resident within two weeks. Strategies for the provisions of a low stimulus environment could be described by staff working within the 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 Low

Evidence:

The district health board wound assessment form being used includes contributing health factors, length of time wound present, any infection /systemic infection, location and size of wound. There is a new order form for treatments and wound progress notes maintained. Short term care plans are in place for skin tears. Chronic wounds are inked to the long term support plan. There is evidence of the wound service and wound care nurse specialist involved in wound care. Behaviour management is described in the long term support plan as behaviour exhibited, management and interventions. The plan is reviewed by the multidisciplinary team six monthly.

Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The gerontology nurse practitioner liaises with the GP and is readily available for advice, resources and education and initiates referrals to the mental health services for the older person as required. A verbal pain inventory is completed for residents on regular or prn pain relief. Pain assessments include non pharmalogical strategies.

Pain assessments are reviewed every six months and initiated for new or exacerbation of chronic pain. Pain monitoring charts are used to completed pre and post analgesia. Abbey pain scales are used for residents unable to verbalise pain.

Residents weights are recorded on the initial nursing assessment on admission and recorded monthly thereafter on the monthly weight chart. The dietitian visits the service to review residents. Mini nutritional assessments (MNA) are completed identifying residents at risk. There is an improvement required around weight loss management.

Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a short term care plan for short term needs or reviews the long term support plan.

Finding:

1) Wound assessment forms are incomplete for one dementia, one psychogeriatric, seven hospital and two residential wounds including date, type of wound, duration of wound and frequency of dressing. Six of 12 wounds in the hospital area did not have evaluations completed as per documented frequency. 2) There is no 15 minute documented monitoring in place as identified for hospital resident following wandering outside of facility as reported in progress notes. 3) The use of controlled drug pain management is not documented in the long term support plan or pain assessment for one PG resident. There are no pain assessments for three rest home residents who identify pain a) resident commenced on XXXXX and prn analgesia. There is no pain assessment for the same resident had a fall with injury requiring analgesia prescribed by the GP. b) Resident seen by GP for XXXX was prescribed anti-inflammatory medication. The medication was not received from the pharmacy and had not been followed up (corrected on day of audit). There is no pain assessment or pain monitoring chart in place c) Resident with XXXX has no pain assessment or pain monitoring chart in place. 4) a) Dementia care resident has lost XXXX over three months and a further XXX in the last month. The long term support plan has not been updated to reflect the current weight loss. The MNA has not been reviewed and weekly weighs have not been implemented as per GP instructions May 2014. b) Hospital resident with increased wandering has had XXXXX over three months. There is no documented interventions, review of MNA or monitoring of food and fluid intake. 5) There has been no update to the support plan for hospital resident admitted to hospital with increased XXXX activity.

Corrective Action:

1) Ensure wound assessment forms are completed and evaluations are completed as per documented frequency. 2) Ensure monitoring is in place for at risk resident of wandering. 3) Ensure pain assessments are completed for new, exacerbation of pain and chronic pain. Ensure residents receive analgesia as prescribed and pain monitoring charts are in place to monitor the effectiveness of pain relief. 4) Ensure weight loss interventions are documented, implemented ad monitored. 5) Ensure the resident support plan reflects the resident's current needs.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service employs a qualified and registered diversional therapist (DT) in the rest home and hospital area and qualified and registered DT in the dementia and psychogeriatric units. They are supported by a relieving activity co-ordinator and a DT in training to provide a seven day week separate programme for the rest home/hospital and the dementia/psychogeriatric units. Care workers are involved in the activities for the dementia and psychogeriatric residents over a 24 hour period and have individual activities that can be carried out with residents on a one on one basis. There are approximately eight volunteers involved in the rest home/hospital programme such as reading to residents, discussion, pampering, cards etc.

There is a combined activity programme for the rest home/hospital residents including (but not limited to); exercise group, reading group, discussion/reminiscence, board games, quizzes, crafts, walking train, newspaper reading, movies, bowls, knitting group. One on one time is spent with residents who choose not to or unable to participate in group activities.

Community visitors include volunteers, visiting chaplain, a variety of musical entertainers and choirs, canine friends, Island singing group, fashion parades, dog shows, inter-home visits. Dementia care and psychogeriatric residents are supervised to attend entertainment and other activities of interest if appropriate. Entertainment and church services are also held in the dementia/psychogeriatric unit. On the day of audit there was an inter-home visit for a bowls competition and afternoon tea. Residents in the dementia/psychogeriatric unit are supervised to attend and participate in the bowls competition. There are weekly outings for the rest home/hospital residents and four times a week for dementia/psychogeriatric residents. There is a van available on-site and access to other vans with wheelchair hoist. Inter-denominational church services are held in the on-site chapel two monthly and Anglican services monthly.

The activity programme in the dementia/psychogeriatric unit is from 10.30am to 8pm and includes (but not limited to); newspaper reading, exercises, painting, craft, scrapbooking, games, singing-a-longs, movies and baking.

The DTs have attended conference within the region, regional DT workshops and attend on-site in-services. Both DTs have a current first aid certificate. The residents have the opportunity to provide feedback on the activities, outings and entertainment at their meetings and through resident surveys. The DT and activity co-ordinator meets and greets new residents and completes a resident "introduction" in consultation with the resident/family/whanau as appropriate. The activity plan is pre-printed and individualised with the resident goals identified. There is on-going evaluation and progress notes completed by the activity team. The activity plan is reviewed six monthly with the RNs and at the same time as the care plan review.

ARHSS 16.5g.iii: A comprehensive social history is completed on or soon after admission and information gathered is included in the support plan. The activity plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

ARHSS 16.5g.iv: Caregivers are observed at various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

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:

Six monthly multidisciplinary evaluations of the long term support plan are completed and involve the GP, RN, primary care worker, diversional therapist and activity co-ordinator, resident/family/whanau input and any other relevant allied health professional such as the physiotherapist or dietitian. The RNs record evaluations on the evaluation of care form that aligns with the corresponding section of care in the long term support plan. The GP completes a three monthly medical examination including a review of the resident's observations and weight and medication review. The primary care worker for the residents is consulted and they have input into the review of the support plans as described by eight care workers interviewed (three rest home, three hospital and two from the dementia and psychogeriatric) Six monthly reviews are evident in seven of 11 files sampled (four hospital, two rest home, one dementia care). One rest home resident, two dementia care and two PG residents have not been at the service long enough for a six month evaluation.

Short term support plans are reviewed regularly with problems resolved or added to the long term support plan if an on-going problem.
D16.4a, ARHSS D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated.
ARC D16.3c: ARHSS D16.3c; All initial care plans were evaluated by the RN within three weeks of admission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

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:

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; care co-ordination centre, community mental health team, physiotherapy, podiatrist, dietitian, nurse practitioner for gerontology and palliative care, wound nurse, war veteran's society. RNs initiate nursing referrals and the GP is notified. The GP refers to specialists as required. There is evidence of GP discussion with families regarding referrals for treatment and options of care.
D16.4c; Re-assessments are initiated in consultation with the GP, nurse practitioners and family. There is evidence of re-assessment for one respite care to rest hone level of care and one hospital resident to PG care.
D 20.1 discussions with the RN identified that the service has access to gerontology and palliative nurse practitioners, nursing specialists such as wound, continence, palliative care nurse, dietitian, speech language therapist, occupational therapist, psychiatric nurse and other allied health professionals.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The RNs interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, and GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. The service uses the district health board yellow envelope system and checklist. Transfer documentation is sighted in residents record recently transferred back to the facility. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

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 Low

Evidence:

There are policies and processes in place that describe medication management. The supplying pharmacy delivers all pharmaceuticals, fortnightly robotic rolls for regular medications and prn blister packs. Expiry dates of prn medications are checked with the weekly order to the pharmacy. There is an improvement required around the checking of medications on delivery against the medication chart. There is one large medication room that contains medical and clinical supplies and four medication trolleys for the rest home and hospital area. There is a locked cupboard in the dementia nurses' station that holds the medications and supplies for dementia care residents. There is a locked medication trolley stationed in the psychogeriatric unit. The hospital medication room holds antibiotic stock (for GP prescribing) and hospital level palliative care stock. The controlled drugs (CD) safe is in the locked rest home/hospital medication room. There is a controlled drug safe in the dementia unit and one week's supply at a time for residents on controlled drugs is transferred out of the hospital CD safe into the dementia care controlled drug safe. Controlled register documentation is sighted for the transferring and receiving of controlled drugs. There is evidence of weekly controlled drug checks in both controlled drug registers. The pharmacy completes a six monthly audit last in June 2014. The pharmacist has signed off RNs and ENs trained to reconcile controlled drugs at the bottom of the page in the controlled drug register. RNs, ENs and senior care workers are assessed as medication competent following education, medication questionnaire and practical medication rounds. Insulin competencies are completed. Competencies and medication education is completed annually. Registered nurses have completed syringe driver training. Standing orders are not in use. There are no self-medicating residents. Eye drops are dated on opening as sighted in all medication trolleys. The medication fridge temperatures (two) are monitored daily and temperatures are within the acceptable range. Oxygen cylinders, concentrators (checked 3/14) and suction is available. Approved containers are used for the disposal of sharps.

The service is in the process of changing over to the Medimap system. The new medimap format has the name of the GP and review date printed on the medication chart. All 22 medication charts (eight hospital, six rest home, four dementia and four psychogeriatric) have been printed within the last three months. Medication charts meet legislative requirements. There are no signing gaps for regular medications. All prn medications signed on the prn administration record are dated and timed. Alerts on medication charts include duplicate name, non-crushable medications and antibiotics. There are records for pulse rates, signing of food supplements, blood sugar levels and vitamin B12 injections.

All 22 resident medication charts sampled identified all charts have recent photo identification (dated) and allergies/adverse reactions noted.

D16.5.e.i. 2, There is evidence of three monthly GP review of medications. PRN medications are prescribed correctly with indications for use.

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:

There are policies and processes in place that describe medication management. The supplying pharmacy delivers all pharmaceuticals, fortnightly robotic rolls for regular medications and prn blister packs. Expiry dates of prn medications are checked with the weekly order to the pharmacy.

Finding:

There is no evidence of checking of medications on delivery against the medication chart.

Corrective Action:

Ensure medications are checked against the medication chart on delivery.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a large workable kitchen that contains one walk-in fridge, two standalone fridges, three freezers and a pantry. The menu is designed and reviewed by a registered dietician at an organisational level and was last reviewed January 2014. There is a seasonal rolling menu. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. Changes to residents' dietary needs are communicated to the kitchen. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Resident meetings are held and meals are discussed. An annual resident satisfaction survey is completed. The last satisfaction survey was held in December 2013 and reported overall satisfaction with food services. The last food satisfaction survey was conducted in June 2014 with very positive results. Regular audits of the kitchen fridge/freezer temperatures and food temperatures are undertaken and documented. Hot food temperatures are documented daily for lunch and tea meals. Food delivery temperatures are documented. Fridge and freezers temperatures are documented daily as sighted. Dish washer temperatures are documented daily. Snacks are available over 24 hours including home baking. The service employs 17 kitchen staff including one kitchen manager/chef, first and second cooks, cooks assistants and kitchen assistants (morning and evening). The kitchen manager/chef has been employed at the service for 11 years and is HACCP trained. The main kitchen supplies meals for the whole facility. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the main kitchen to the dining area adjacent to it. Other dining areas have food transported in a baine marie to the rest home dining room and individual not plates with thermal covers to the dementia and psychogeriatric units

Special diets being catered for include soft diets, puree diets, minced moist, one gluten free and diabetic.

Residents and family interviewed report satisfaction with food choices, meals are well presented (observed) and alternative meals are offered, as required. Tea and coffee is available in family areas.

Special equipment is available and this is assessed as part of the initial nursing assessment. Lipped plates, special cutlery and feeding cups were evidenced in use by residents on the day of audit.

The kitchen has a certificate from the council which expires 31 August 2014.

E3.3f, ARHSS D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

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 and chemicals are stored securely. Laundry and sluice rooms are locked. Bulk chemicals are stored in a locked storage area adjacent to the facility until required. Product use charts are available. The risk management register identifies that chemicals are a hazardous substance, and staff indicated a clear understanding of processes and protocols. Gloves, arm protectors, aprons, and goggles are available for staff. Interviews with eight care workers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff education around safe chemical handling and management of waste is covered during orientation of new staff and an education session was provided in April 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are three maintenance persons who work full time including weekends and on call. There are also two other part time maintenance staff. Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires on 12 June 2015. Electrical equipment is checked annually and this was last completed in July 2014. All medical equipment was calibrated by Dental and Medical and all hoists and electric beds were checked and serviced at this time, in March 2014. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. There is sufficient space to allow the safe use of mobility equipment. Safety rails appear appropriately located. There is a maintenance work notification form/books for staff to communicate with maintenance staff issues and areas that require attention. Residents were observed moving freely around the areas with mobility aids where required. There is a chapel onsite with is also used by the community.

The external areas are well maintained and gardens are attractive. There is garden furniture and plenty of shade. There is wheelchair access to all areas. The garden is secure and there is shade. All hazards have been identified in the hazard register.

E3.4d, ARHSS D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. Interviews with two care workers from the psychogeriatric unit confirmed there was adequate equipment.

E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; ARHSS D15.3b there is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

The facility has four wings (hospital, rest home, a secure psychogeriatric unit and a secure dementia unit). There are showers and toilets throughout the facility. There are adequate visitor and staff toilet facilities available. Communal toilets and bathrooms have appropriate signage and shower curtains installed. Six residents interviewed (two hospital and four rest home) report their privacy is maintained at all times.

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 it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space. Eight care workers (six from rest home and hospital and two from dementia and psychogeriatric) report that rooms have sufficient rooms to allow cares to take place.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There are several large lounges in the rest home/ hospital and large separate dining room that is shared by rest home/hospital residents. There is another dining room for rest home residents. There are two lounges and a dining area in each of the psychogeriatric unit and the dementia unit. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and six residents interviewed (four rest home and two hospital) report they can move around the facility and staff assist them if required.

ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. There are dedicated cleaning and laundry staff. All laundry is done on site. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The service has a secure area for the storage of cleaning and laundry chemicals are stored in the laundry. All chemicals are labelled with manufacturer's labels. The service has a laundry service manual. There are cleaning schedule checklists. The laundry is divided into a "dirty" and "clean" area. MSDS are displayed on walls. There is a closed chemical system for the washing machines. Staff training is provided in chemical safety annually. Last training was conducted April 2014 and 19 staff members attended. Chemical training and IPC training was last conducted for kitchen and cleaning staff and 11 staff attended. Cleaning and laundry audits were last undertaken in March and April 2014 and results are communicated to staff (# link 1.2.3.6). Cleaning is a seven day a week service. The laundry and cleaning rooms are designated areas and clearly labelled. There are rooms available for storage of chemicals. All chemicals are labelled with manufacturer's labels. MSDS are available in folders in the laundry and on the walls in the cleaner's cupboards. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety and emergency response was held in May and July 2014. Fire evacuations are held six monthly. A fire evacuation was held in February 2014 (44 staff attended) and June 2014 (46 staff attended).

There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in storage a large container at reception this includes and up to date register of all residents' details. There is an approved evacuation plan dated November 2012.

The facility is well prepared for civil emergencies and has emergency lighting and two BBQ's. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for four days are kept in the kitchen. Extra blankets are also available.

Hoists have battery back and there are batteries that can be used to operate electric beds in the event of a power failure. The service has a stand by generator. At least three days stock of other products such as incontinence products and personal protective equipment (PPE) are kept. Fire alarms and hose reels are checked by a contracted company. Testing and tagging of electrical appliances was last conducted in July 2014 and calibration of medical equipment was conducted in March 2014. Security policies and procedures are in place

The call bell system is available in all areas. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. Call bells activate pagers and are displayed on a computer screen at the main reception. All registered nurses and care workers on duty carry pages. There are 36 pagers and these are maintained by the maintenance staff with weekly checks conducted. During the tour of the facility residents were observed to have easy access to the call bells in their bedrooms. Relative interviews (total 14) reported there were areas of improvement including timely call bell response. Interview with the Director Services for Older People (DSOP) and the Quality Manager indicate an awareness of the feedback and report work is being undertaken to address the issues raised such as performance management of staff and on-

going monitoring of call bell response (noted in internal audit data). During the audit a test of the call bell response time was conducted and there was no response from staff for over 15 minutes. This is an area requiring improvement.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: PA Low

Evidence:

The call bell system is available in all areas. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. Call bells activate pagers and are displayed on a computer screen at the main reception. All registered nurses and care workers on duty carry pages. There are 36 pagers and these are maintained by the maintenance staff with weekly checks conducted. During the tour of the facility residents were observed to have easy access to the call bells in their bedrooms.

Finding:

Interview with the Director Services for Older People (DSOP) and the Quality Manager indicate an awareness of the feedback and report work is being undertaken to address the issues raised such as performance management of staff and on-going monitoring of call bell response (noted in internal audit data). During the audit a test of the call bell response time was conducted and there was no response from staff for over 15 minutes.

Corrective Action:

Ensure that all call bells are answered in a timely manner.

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

Criterion 1.4.7.6 (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:

The facility has radiators and heat pumps which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored.

Six residents (four rest home and two hospital) and 14 relatives (10 hospital, one rest home dementia and three psychogeriatric) interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in resident's rooms.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)
Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: PA Low

Evidence:

Documented systems are in place to ensure the use of restraint is actively minimized. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.

Interview with the restraint co-ordinator was conducted and evidences that there is one resident with restraint in the psychogeriatric unit and 16 restraints for 11 residents receiving hospital level care. There are nine enablers for seven residents receiving hospital level care. The restraint and enabler registers sighted confirmed the number of restraints and enablers

There are bi monthly meetings of the restraint committee; terms of reference and meeting minutes were sighted for June 2014.

Restraint practises are also discussed at the monthly quality improvement meetings (# link 1.2.3.6).

Staff interviews and staff records evidence guidance has been given on restraint practice, enabler usage and prevention and/or de-escalation techniques. The definition of restraint and enabler is congruent with the definition in NZS 8134.0. The process of assessment and evaluation of enabler use is in place. Currently there are seventeen restraints (three lap belts, 11 bed rails and three lap tables) and nine enablers (two lap belts and seven bed rails) in place. Two files were reviewed for residents with enablers. One resident's file reviewed did not show evidence that risks related to enabler use are documented in the residents support plan. This is an area requiring improvement.

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

Staff education on RMSP /Enabler and challenging behaviour is conducted as part of the compulsory training days, sighted attendance records for March and April 2014.

Restraint audit was conducted in April 2014.

A register for each restraint and enabler is completed that includes a three-monthly evaluation.

E4.4a the care plans reviewed focus on promotion of quality of life and minimise the need for restrictive practises through the management of challenging.

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:

Documented systems are in place to ensure the use of restraint is actively minimized. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Staff interviews and staff records evidence guidance has been given on restraint practice, enabler usage and prevention and/or de-escalation techniques. The definition of restraint and enabler is congruent with the definition in NZS 8134.0. The process of assessment and evaluation of enabler use is in place. Currently there are seventeen restraints (three lap belts, 11 bed rails and three lap tables) and nine enablers (two lap belts and seven bed rails) in place. Two files were reviewed for residents with enablers.

Finding:

One residents file reviewed did not show evidence that risks related to enabler use is documented in the residents support plan.

Corrective Action:

Ensure that all residents with enablers have risks identified related to enabler use and that these are documented in the residents support plan.

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator is the physiotherapist who has been at the service for two years. The clinical coordinator for the hospital/rest home is in the process of taking over the position. Assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.

Interview with the restraint co-ordinator was conducted and evidences that there is one resident with restraint in the psychogeriatric unit and 16 restraints for 11 residents receiving hospital level care. There are nine enablers for seven residents receiving hospital level care. The restraint and enabler registers sighted confirmed the number of restraints and enablers. Review of four clinical files of residents' utilising restraint evidence assessments, consent, monitoring and review of restraint use is conducted in all four files. One file had documented evidence of risks related to restraint use in the residents support plan (# link 2.2.3.4).

The restraint committee reviews restraint use bi monthly and restraint is also discussed at monthly quality improvement meetings, sighted minutes of meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: PA Low

Evidence:

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

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;

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

Attainment and Risk: PA Low

Evidence:

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. All four files reviewed had completed assessment forms. One file from four files reviewed has a support plan that reflects risk.

Finding:

Three file from four files reviewed does not show evidence that the resident's support plan reflects risk.

Corrective Action:

Ensure that all residents have documented risks related to use of restraint in the residents support plan.

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

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 service has documented review of restraint every three months. The restraint process considers the items listed in # 2.4.1. In the four restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner for three residents. This is an area requiring improvement.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The service has documented review of restraint every three months. The restraint process considers the items listed in # 2.4.1. In the four restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner for three residents.

Finding:

One in four resident files reviewed did not show evidence of three monthly evaluation.

Corrective Action:

Ensure that all residents with restraint have documented evaluation at least three monthly.

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The role of the infection prevention and control (IPC) coordinator is held by a registered nurse from the dementia/psychogeriatric unit. She has been employed at the service for three years. She has just returned from three months parental leave and has been in the position of IPC two months prior to taking parental leave. The clinical coordinator from the hospital/rest home assumed the position of IPC over the parental leave time. The quality manager oversees the IPC and has supported the clinical coordinator. The

IPC coordinator can access external specialist advice from GP's, laboratories and DHB IPC specialists when required. The IPC programme is appropriate for the size and complexity of the service. There is an IPC committee including the IPC coordinator, and representatives from maintenance, registered nurses, care workers, household/laundry and kitchen. All members meet monthly. The IPC coordinator reports to the manager and the quality team. IPC is an agenda item at monthly quality meetings that looks at analysis, future prevention and how the IC programme is working. Analysis benchmarks with QPS and three other PSS providers quarterly. The service also subscribes to Bug Control. The programme is approved and reviewed annually by the quality manager, coordinator and senior management team and external expertise when required. The programme has recently been reviewed against the 2014 bug control policies. Policies updated included isolation precautions, infection prevention, infectious disease table and ESBL. Objectives of IPC programme include but not limited to: ensure staff have an understanding of how infection is spread, to promote the flu injection, the importance of accurate data for QPS, policy review against bug control 2014, participating in quality improvement progress, assisting in employee health programmes and providing education, to staff, residents, families and volunteers. IPC is a standing agenda item at the monthly staff meetings and quality meetings (minutes viewed) (# link 1.2.3.6). Staff are informed about IPC practises and reporting. They can contact the IPC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IPC coordinator and entered into the infection register.

There is a job description for the IPC coordinator including the role and responsibilities of the position. There are also job descriptions for all IPC committee members. Staff and residents are encouraged to have the flu vaccine. The service had norovirus outbreaks in March April and May 2014.

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): *(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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The registered nurse form the dementia/psychogeriatric unit is the IPC coordinator and. There is an IPC committee including the IPC coordinator, and representatives from maintenance, registered nurses, care workers, household/laundry and kitchen. All members meet monthly. The IC coordinator reports to the manager and the quality team. Data is entered on to the QPS. IPC matters are taken to all staff and quality meetings (minutes reviewed) (# link 1.2.3.6). The IPC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. She has the main responsible for reviewing the IC programme annually with support from the quality manager. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete two monthly infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

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:

The service has infection control policies and an infection control manual which reflect current practise. The policies and infection control manual has recently been reviewed and updated against the bug control policies 2014. The IPC programme defines roles and responsibilities of the IPC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IPC coordinator. The IPC programme is reviewed annually by the IPC coordinator who can access external specialist advice to do this.

D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.

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 IPC coordinator is the registered nurse who works full time in the dementia/psychogeriatric unit who has undertaken IPC training. All new staff receive infection control education at orientation including hand washing and preventative measures .Two monthly infection control education occurs. Three staff members (two clinical coordinators and the administrator) have attended outbreak management in April 2014. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained as evidenced from interview with fourteen relatives (10 hospital, one dementia and three psychogeriatric) when the service experienced norovirus outbreaks in March, April and May 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for all infections. 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 collated monthly and reported at both the infection control and integrated meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Infection rates are benchmarked by QPS benchmarking service. Hand hygiene audits are included in the audit schedule (last completed March2014). 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. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager and to organisational management. The recent Norovirus outbreaks were reported to organisational management and to Public Health South. The outbreak in March 2014 lasted approximately two weeks and affected 27 residents and 23 staff in the rest home and hospital areas only. The outbreak in April lasted approximately one week and affected 15 residents from the rest home and hospital area, 12 from dementia and two from psychogeriatric. There were 23 staff affected. The outbreak in May 2014 lasted approximately one week and affected three residents in rest home and hospital area and one resident in dementia. There were no staff affected. The service has held a debrief meeting (23 June 2014) to evaluate the outbreak and service response with an action planned developed around identified areas for improvement for the future

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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