

# Presbyterian Support Southland - Vickery Court

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Current Status: 4 August 2014

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

## General overview

Vickery Court is part of the Presbyterian Support Southland group and is certified to provide hospital (medical and geriatric), rest home and residential disability (physical) level care for up to 88 residents. On the day of the audit there were 38 hospital residents, 34 rest home and nine residential disability (physical) residents.

All residents are cared for in the same building. Vickery Court's manager is a registered nurse and is well qualified for the role. There are well developed and implemented systems and policies to guide appropriate care for residents. A quality programme is being implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care.

There are five improvements required around meeting minutes, incident reporting, training, interventions and medication management.

## Audit Summary as at 4 August 2014

Standards have been assessed and summarised below:

### Key

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 4 August 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 4 August 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 4 August 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### Safe and Appropriate Environment as at 4 August 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 4 August 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 4 August 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 4 August 2014

### Consumer Rights

Vickery Court 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 process. 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 implemented and complaints and concerns are managed and documented. Residents interviewed verified on-going involvement with community.

### Organisational Management

Vickery Court 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 three improvements required around meeting minutes, incident reporting and training.

### Continuum of Service Delivery

The service has a policy for admission and entry to the facility. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents confirm 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 and 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, implementation and documentation of assessment outcomes, and pain management. Resident files are integrated and include notes by the GP and 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. 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 and transcribing. 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. The company dietitian reviews the four weekly menu. Food services staff are aware of resident's likes/dislikes and alternative choices are offered, vegetarian and gluten free meals are provided.

### **Safe and Appropriate Environment**

Vickery Court is a purpose built facility. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are personalised and have ensembles. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. Outdoor areas are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned maintenance schedule. All chemicals are stored safely throughout the facility. The cleaning service maintain a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

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

There is a documented definition of restraint and enablers which is congruent with the definition in the Health and Disability Services Standards. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service has 13 enablers in use and three restraints. A monthly restraint and enabler register is maintained. There is a restraint co-ordinator and restraint committee. The GP is involved in the consent process for enabler and restraint. Restraint minimisation and challenging behaviour education has been attended.

### **Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (nurse manager) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the

facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Presbyterian Support Southland
<b>Certificate name:</b>	Presbyterian Support Southland - Vickery Court
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Vickery Court
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	<b>Start date:</b> 4 August 2014 <b>End date:</b> 5 August 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	81

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	15	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	15	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	30	Total audit hours off site	18	Total audit hours	48
Number of residents interviewed	9	Number of staff interviewed	21	Number of managers interviewed	2
Number of residents' records reviewed	9	Number of staff records reviewed	11	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	87	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology	3			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 Wednesday, 17 September 2014

## Executive Summary of Audit

### General Overview

Vickery Court is part of the Presbyterian Support Southland (PSS) group and is certified to provide hospital (medical and geriatric), rest home and residential disability (physical) level care for up to 88 residents. On the day of the audit there were 38 hospital residents, 34 rest home and nine residential disability (physical) residents. Five of the residential disability residents require hospital level care and four rest home level care. All residents are cared for in the same building. Vickery Court's manager is a registered nurse and is well qualified for the role. There are well developed and implemented systems and policies to guide appropriate care for residents. A quality programme is being implemented. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. There are five improvements required around meeting minutes, incident reporting, training, interventions and medication management.

### Outcome 1.1: Consumer Rights

Vickery Court 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 process. 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 implemented and complaints and concerns are managed and documented. Residents interviewed verified on-going involvement with community.

### Outcome 1.2: Organisational Management

Vickery Court 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 three improvements required around meeting minutes, incident reporting and training.

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

The service has a policy for admission and entry to the facility. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents confirm 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 and 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, implementation and documentation of assessment outcomes, and pain management. Resident files are integrated and include notes by the GP and 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. 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 and transcribing. 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. The company dietitian reviews the four weekly menu. Food services staff are aware of resident's likes/dislikes and alternative choices are offered, vegetarian and gluten free meals are provided.

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

Vickery Court is a purpose built facility. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are personalised and have ensuites. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. Outdoor areas are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned maintenance schedule. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

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

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service has 13 enablers in use and three restraints. A monthly restraint and enabler register is maintained. There is a restraint co-ordinator and restraint committee. The GP is involved in the consent process for enabler and restraint. Restraint minimisation and challenging behaviour education has been attended.

### **Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (nurse manager) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate

training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	45	0	5	0	0	0
<b>Criteria</b>	0	96	0	5	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	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.200 8	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.200 8	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) Resident meeting minutes reviewed do not consistently report that issues raised are followed through such as the January minutes where it was reported more 'jam jars and spreads' were requested, there is no reported outcome at the February meeting. b) Infection control meeting minutes do not always report	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)
				follow up actions/strategies to address issues reported: (i) a number of agenda items do not have any information regarding the discussion against agenda items such as I/C report and H&S report; (ii) the March (2014) minutes report the [then] recent norovirus outbreak however there is no reported action/responsibilities; (iii) infection rates are reported at these meetings, there is no actions/strategies to address/review/monitor infection rates – noting members of the IC committee report QPS tracking higher than average for UTI's.		
HDS(C)S.200 8	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.200 8	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	Two (of four) resident files reviewed reported: a) 'XXXXX and b) 'XXXXX. There was no associated incident forms. It is noted the manager and senior registered nurse investigated both at the time of audit and informed neither resident had a XXXXX. There were no other instances where events reported in progress notes did not have an accompanying incident report, the risk against this finding is there considered to be low.	Changes in resident health status are reported through the incident reporting process.	60
HDS(C)S.200 8	Standard 1.2.7:	Human resource management	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Human Resource Management	processes are conducted in accordance with good employment practice and meet the requirements of legislation.				
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	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 17 staff were overdue.	Staff attend prescribed training.	180
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	The following shortfalls have been identified in resident files reviewed; (i) There is no wound assessment, short term care plan or evaluations for a rest home resident with re-occurrence of XXXX as documented in the wound progress notes. (ii) The long term support plan does not reflect current pressure area interventions for one hospital resident with an increase of pressure area risk as per the reviewed risk assessment. (iii) Wound assessments and evaluations are incomplete in four out of five wounds. (iv) Hospital resident admitted XXX with known behaviours does not have a behaviour assessment completed on admission. The behaviour monitoring form has not been recommenced with recent	Ensure assessments and interventions are documented as required.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>challenging behaviours as reported in the progress notes. (v) There is no abbey pain scale used to assess pain levels for one rest home younger disabled resident receiving PRN pain relief. There is no pain monitoring chart in place. (vi) There is no pain monitoring chart in place to monitor the effectiveness of pain relief for one rest resident with reports of breakthrough pain. (vii) Two hospital residents at high risk of falls do not have the falls risk algorithm completed that identifies falls prevention management and interventions required. (viii) One rest home resident admitted from hospital XXXXX. The MNA identified the resident at risk of XXXXX on admission. There is no short term care plan, interventions or dietitian input regarding the weight loss.</p>		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	1) There is no evidence of checking of medications on delivery against the medication chart. 2) There is transcribing on four out of 18 PRN signing sheets (two rest home and two hospital).	1) Ensure medications are checked against the medication chart on delivery. 2) Ensure transcribing ceases.	60

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Vickery Court 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 seven care workers (three rest home/residential disability and four hospital/residential disability) demonstrate an understanding of the Code. Elder abuse training is included in the compulsory study day (link 1.2.7). Residents interviewed (four rest home, one residential disability/hospital and four 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 monthly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents interviewed (four rest home, one residential disability/hospital and four hospital) inform information has been provided around the Code. The manager 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 (link 1.2.7). A resident satisfaction survey is completed annually (December 2013). The December survey informed an overall satisfaction with the service as 89.5% for hospital residents and 90.7% for rest home residents (note the residential disability residents are included in these totals).

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 seven care workers describe how choice is incorporated into resident cares. Interview with residents (four rest home, one residential disability/hospital and four hospital) inform staff are respectful. 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. Interviews with residents were positive about the care provided.

D4.1a Nine 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.

**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 Vickery Court 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. Discussion with residents (four rest home, one residential disability/hospital and four 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.

### 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 four registered nurses and two enrolled nurses confirm an awareness of professional boundaries. Interview with seven care workers (three rest home/residential disability and four hospital/residential disability) could discuss professional boundaries in respect of gifts.

### 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:**

Vickery Court 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 Careerforce programme being implemented. There is evidence of education being supported outside of the prescribed training plan such as advanced care plan training, webinar wound care sessions offered by the Southern PHO and those offered by the primary health special interest group.

ARC A2.2 Services are provided at Vickery Court 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.

Discussions with residents (four rest home, one residential disability/hospital and four hospital) were positive about the care they receive. Interview with seven care workers (three rest home/residential disability and four hospital/residential disability) inform they are well 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. Ten incident forms reviewed from June and July 2014 identify family were notified following a resident incident. Interview with seven care workers (three rest home/residential disability and four hospital/residential disability), 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 were not interviewed during the audit.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### **Standard 1.1.10: 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 four RNs, two enrolled nurses and seven care workers interviewed are knowledgeable in the informed consent process. All nine resident files (four hospital, three rest home and two younger persons) 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 being introduced and sighted in one recent rest home admission file.

D13.1 there were nine 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 seven care workers (three rest home/four hospital), four registered nurses and two enrolled nurses identify that consents are sought in the delivery of personal cares and this is confirmed by nine residents (four rest home, one residential disability/hospital and four 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 manager confirms practice. Interviews with residents (four rest home, one residential disability/hospital and four hospital) confirm that they are aware of their right to access advocacy.

D4.1d; No family members were interviewed as part of this audit

ARC D4.1e. The resident files include information on residents' 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: Interview with residents (four rest home, one residential disability/hospital and four 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 (four 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 seven care workers (three rest home/residential disability and four hospital/residential disability), the activities coordinator, residents (four rest home, one residential disability/hospital and four hospital) confirm residents are supported and encouraged to remain involved in the community and external groups.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a complaints policy to guide practice. The manager leads the investigation and management of complaints (verbal and written). There are two complaints (and compliments) log/registers that records activity by service type – i.e. Rest home and hospital - in an ongoing fashion. Complaints are discussed at the monthly quality meeting. Complaints forms are visible at the entrance of the facility. There are three recorded 2014 complaints for the rest home and three for the hospital. All have been investigated and a response provided to the complainant in a timely manner. There were 11 recorded complaints across the 2013 year. Discussion with residents (four rest home, one residential disability/hospital and four hospital) confirm they are aware of how to make a complaint. There have been a number of compliments that have been received across the 2014 period.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Vickery Court provides care for up to 88 residents across three certified service types – rest home, hospital and residential disability (physical) services. The residents under the residential disability – physical contract (nine), have either hospital level (five) or rest home level (four) care needs. All residents are cared for in the same building. On the day of audit there were 34 rest home residents (including one respite), 38 hospital residents, five younger people with hospital needs and four younger people with rest home level needs. There are three large double rooms, two of which had married couples in them at the time of audit (one room was vacant).

Vickery Court is part of the Presbyterian Support Southland group who has developed a charter that sets out its vision and values. The manager of Vickery Court reports to the Director Services for Older Person (DSOP), who is part of the executive management team who report to the chief executive. 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 develop advanced nursing roles. Vickery Court has an identified vision, values and goals 2014 year. Goals for Vickery Court include (but not limited to): timely complaints resolution, 90% attainment on resident/relative satisfaction survey, all incidents and infections are investigated. 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 planning or end August/September. This projects 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.

The service is managed by an experienced registered nurse who has been the manager at Vickery Court for ten years. She is supported by a team of registered nurses have experience within the aged residential care environment. 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.

**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 senior registered nurse will cover the manager's role. Both the manager and the registered nurse who is 'two IC' 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.

### 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:**

Vickery Court 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 demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends) and most recently InterRAI – which is in the process of being implemented. There is a quality manager (registered nurse) for the PSS group who has been with the service since November 2013. The quality manager supports Vickery Court 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.

Vickery Court 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. In addition infection control meeting minutes do not always report follow up actions/strategies to address issues reported. These are issues requiring improvement.

Vickery Court 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 a comprehensive H&S and risk management programme in place including policies to guide practice. One of the care workers is the health and safety coordinator for the facility who monitors staff accidents and incidents. She is supported by the manager.

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.

**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:**

Vickery Court has a meeting schedule in place that is being implemented included monthly quality meetings, quarterly staff meetings and monthly infection control and health and safety meetings. Resident meetings are held monthly. Meetings are minuted and quality information is shared across the various meetings – eg. incidents, infections, staff accidents, audits.

**Finding:**

- a) Resident meeting minutes reviewed do not consistently report that issues raised are followed through such as the January minutes where it was reported more 'jam jars and spreads' were requested, there is no reported outcome at the February meeting.
- b) Infection control meeting minutes do not always report follow up actions/strategies to address issues reported: (i) a number of agenda items do not have any information regarding the discussion against agenda items such as I/C report and H&S report; (ii) the March (2014) minutes report the [then] recent norovirus outbreak however there is

no reported action/responsibilities; (iii) infection rates are reported at these meetings, there is no actions/strategies to address/review/monitor infection rates – noting members of the IC committee report QPS tracking higher than average for UTI's.

**Corrective Action:**

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. Ten incident forms reviewed across June and July (a mix of rest home and hospital) indicate appropriate intervention has been undertaken. Four files were traced and there were two instances of broken skin reported in progress notes that did not have an associated incident form and 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.

**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:**

Two (of four) resident files traced reported: a) 'XXXXX and b) 'XXXXXX. There was no associated incident forms. It is noted the manager and senior registered nurse investigated both at the time of audit and informed neither resident had XXXXXX. There were no other instances where events reported in progress notes did not have an accompanying incident report, the risk against this finding is there considered to be low.

**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:** PA Low

**Evidence:**

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Eleven staff files were reviewed (three registered nurses – one infection control coordinator, one restraint coordinator; one enrolled nurse; four care workers – one is the health & safety rep; cook, diversional therapist, physiotherapy assistant) and all had relevant documentation relating to employment. Of the files reviewed there were two performance appraisals overdue for review, these have been scheduled and as 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 (seven 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 a number of staff who were overdue to attend a compulsory day and this is an area for improvement. 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 seven care workers confirm participation in the Careerforce 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.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

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. 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 seven care workers confirm participation in the Careerforce training programme

**Finding:**

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 17 staff were overdue.

**Corrective Action:**

Staff attend prescribed training.

**Timeframe (days):** 180 (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: AM: one RN, two enrolled nurses (EN)s, 11 care workers (for varying times), PM: one RN, one EN, 10 care workers, ND: one RN, four care workers. The manager is on-call, with a named registered nurse as '2-IC'. The care workers and residents interviewed inform there are sufficient staff on duty at all times.

### 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 for rest home or hospital level of care. A placement authority form is sent to the receiving facility. The manager (registered nurse – 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 a dmission.

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. Nine signed admission agreement forms are sighted. Full documents are held at head office. Residents (four rest home, one residential disability/hospital and four hospital) 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.

#### **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 and hospital level of care for up to 88 residents. There are rest home and hospital wings, the young disabled residents are in either wing dependant on need (four rest home and five hospital level). D.16.2, 3, 4: The nine resident files sampled (three rest home, four hospital, one young disabled rest home level and one young disabled hospital level) identifies the manager (RN) or registered nurse (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.

Nine 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. 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, community workers, dietitian, physiotherapist and podiatrist. All nine resident files sampled included evidence of resident/relative input into the initial nursing assessment and reviews.

D16.5e: Eight of nine resident files sampled identified that the GP had seen the resident within two working days. One hospital resident had been transferred from hospice and was seen by a locum GP within 4 days of admission.

It was noted in six of nine 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. He visits weekly and on request for RN resident concerns. The GP is available 24/7 for his palliative patients. There is an after hour's clinic or the emergency department for more urgent attention. The GP states there is no problem with enrolling new patients who come into the home. The GP arranges to meet with families to discuss health concerns and options for treatment and management. There is good communication and liaison between the nurse practitioners and the RNs. The GP is complimentary about the care the residents receive.

There is a verbal and written handover period between the shifts for rest home and hospital that ensures staff are kept informed of resident's health status and any significant events. The verbal handover from the enrolled nurse to the afternoon RN is observed on the day of audit and sufficient resident information is given to safely deliver resident cares.

There is an employed physiotherapist four hours twice a week to conduct initial resident physiotherapist assessments, follow-up resident referrals and post falls incidents and exercise programme. The physio assistant is employed from 9am to 2pm 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.

Tracer methodology; Hospital resident

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

Tracer methodology; Rest home -

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

Tracer methodology; Hospital level

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 nine resident files sampled evidenced an initial nursing assessment and support care plan with reference to the information gathered on admission. Residents 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 (adapted from Morse) 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. See improvements identified 1.3.6.1

### **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 one rest home resident file. The advance care plan documents the resident or family wishes in regards to end of life care including cultural and spiritual needs. There is documented evidence of discussions held with the resident and/or family and regular reviews. Three RNs have completed InterRAI training and the service is gradually changing over to InterRAI assessments as they fall due.

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. See improvements identified 1.3.6.1.

Medical GP notes and allied health professional progress notes are evident in the nine residents integrated files sampled. Residents interviewed are positive and complimentary about the staff, clinical and medical care provided.

D16.3k, Short term care plans are in use for changes in health status.

Nine out of nine resident files reviewed identified that family have been involved in the support plan process.

### 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. Residents (four rest home, one residential disability/hospital and four hospital) interviewed state their needs are 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 includes contributing health factors, length of time wound present, any infection /systemic infection, location and size of wound. The PSS wound assessment also in use could be more comprehensive. There is a new order form for treatments and wound progress notes maintained. There is an improvement required around wound management and documentation. 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. All hospital level beds have pressure area grade mattresses. There is an improvement required around documentation of pressure area interventions to reflect the current pressure area risk. There are no interventions or wound management in place for two residents reported in progress notes to have slightly broken skin (link 1.2.4).

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. 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 behavioural assessment and behaviour monitoring.

A verbal pain inventory is completed for residents on regular or prn pain relief. Pain assessments include non-pharmacological 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.

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, use of sensor mats, physiotherapy reviews, ensuring the call bell is within reach and the environment is clutter free. There is an improvement required around the completion of falls risk documentation.

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.

### **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 includes contributing health factors, length of time wound present, any infection /systemic infection, location and size of wound. The PSS wound assessment also in use could be more comprehensive. There is a new order form for treatments and wound progress notes maintained. 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 an improvement required around wound management and documentation of pressure area interventions.

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 pharmacological 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.

Falls prevention strategies include review of falls risk assessments, use of sensor mats, physiotherapy reviews, ensuring the call bell is within reach and the environment is clutter free. Falls risk assessments are completed on admission and reviewed at least six monthly or earlier as required for residents who fall.

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.

#### **Finding:**

The following shortfalls have been identified in resident files reviewed; (i) There is no wound assessment, short term care plan or evaluations for a rest home resident with re-occurrence of XXXXX as documented in the wound progress notes. (ii) The long term support plan does not reflect current XXXXX interventions for one hospital resident with an increase of XXXXX risk as per the reviewed risk assessment. (iii) Wound assessments and evaluations are incomplete in four out of five wounds. (iv) Hospital resident admitted XXXXXX does not have a XXXXX sssessment completed on admission. The behaviour monitoring form has not been re-commenced with recent challenging behaviours as reported in the progress notes. (v) There is no abbey pain scale used to assess pain levels for one rest home younger disabled resident receiving PRN pain relief. There is no pain monitoring chart in place. (vi) There is no pain monitoring chart in place to monitor the effectiveness of pain relief for one rest resident with reports of breakthrough pain. (vii) Two hospital residents at high risk of falls do not have the falls risk algorithm completed that identifies falls prevention management and interventions

required. (viii) One rest home resident admitted from hospital in XXXXXXX in one month. The MNA identified the resident at risk XXXXXX on admission. There is no short term care plan, interventions or dietitian input regarding the weight loss.

**Corrective Action:**

Ensure assessments and interventions are documented as required.

**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) three days a week for the rest home wing and an activity co-ordinator (undergoing career force training) fulltime for the hospital wing. Both staff have recently attended the three day DT conference. The DT is on the regional committee and assist in the co-ordination of the two monthly workshops. Both staff hold a current first aid certificate. There is a combined activity programme with activities held in either the large lounge or the smaller lounges in each wing. Separate activities are held for rest home and hospital residents that meets their physical and cognitive abilities and resident may choose which activities they would like to attend. On two days of each week the activities are combined. The programme is implemented Monday to Friday. A variety of exercises are held each morning with balls, music, weights and chair exercises. The physiotherapist takes one session per week. Activities include (but not limited to); paper reading, beauty therapy (pamper sessions, massage, make-up, manicures), quizzes, scrabble, housie, poetry, library trolley, happy hour , crafts, baking, movies and popcorn and choir practice. One on one time is spent with residents who choose not to or unable to participate in group activities. Community visitors include volunteers, entertainers, canine friends, and school and kindergarten children. Residents maintain community links with groups such as inter-home visits, blind centre, stroke club, rural women’s, women’s fellowship, probus and senior citizens, Regular interdenominational church services and bible study is held weekly. Birthdays, festive occasions, ethnic themes and international days are held. Mystery drives, shopping trips, lunches and outings are arrange on a regular basis for rest home and hospital residents. The residents have the opportunity to provide feedback on the activities, outings and entertainment at their meetings and through resident surveys. There is a resident committee and resident advocate. 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 ongoing 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. The activity co-ordinator completes individual activity plans in consultation with the younger persons and their family that ensure their personal interests, hobbies and community links are maintained such as visitors, shopping and outings of interest. One on one time is spent with the younger persons daily as evidenced in the recreational records. A choice of individual activities are offered as well as participation in the group activities.

### 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 seven care workers interviewed (three rest home and four hospital) and two enrolled nurses. Six monthly reviews are evident in four of nine files sampled (one hospital, one rest home and two younger persons). Three hospital residents and two rest home residents had 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 ongoing problem.

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

ARC 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, assessment and rehabilitation centre, radiology, physiotherapy, podiatrist, eye clinic, community worker for disability action group, dietitian, nurse practitioner for gerontology and palliative care and wound nurse. 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. Currently there is one respite care resident awaiting assessment for rest home level of care.

D 20.1 discussions with the RN identified that the service has access to a 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 RN 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. There is an improvement required around the checking of medications on delivery against the medication chart. There are two locked

medication rooms (rest home and hospital). The hospital medication room holds antibiotic stock (for GP prescribing) and hospital level palliative care stock. The controlled drugs (CD) safe is kept in the locked RN office. The returns are kept in the locked medication rooms until collected.

The registered nurses (RN's), enrolled nurses (EN) and senior care workers administering medications have completed an annual medication competency. Annual medication education is attended. RNs have syringe driver competency and complete annual refreshers with the PSS Palliative Care Nurse Practitioner as they fall due. Medication rooms contains adequate supplies of pharmaceuticals, treatments, clinical supplies and the medication trolleys. The controlled drug (CD) stock is checked and signed in the CD register weekly. There is a six monthly pharmacy audit conducted. CD's administered are signed by two medication competent staff on the signing administration sheet. Standing orders are not in use. There are three self-medicating residents. A self-medication assessment has been completed for each resident and is reviewed three monthly by the RN and GP. Self-administration is monitored and signed on each shift. The medications are stored safely in the bedroom. Eye drops are dated on opening. The hospital medication fridge temperature is monitored weekly and within the acceptable range. Oxygen cylinders, concentrators and suction is available. Emergency medications (glucagon) is available in the hospital medication room. Approved containers are used for the disposal of sharps.

The service is in the process of changing over to the Medimap system. Seventeen of 18 medication charts are in the new medimap format with the name of the GP and review date printed on the medication chart. All charts have been printed within the last two 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. There is an improvement required around transcribing.

Eighteen 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:**

The supplying pharmacy delivers all pharmaceuticals, fortnightly robotic rolls for regular medications and prn blister packs. There are two locked medication rooms (rest home and hospital). The hospital medication room holds antibiotic stock (for GP prescribing) and hospital level palliative care stock. There are no signing gaps on the administration signing form for regular medications. All prn medications signed on the prn administration record are dated and timed.

**Finding:**

1) There is no evidence of checking of medications on delivery against the medication chart. 2) There is transcribing on four out of 18 PRN signing sheets (two rest home and two hospital).

**Corrective Action:**

1) Ensure medications are checked against the medication chart on delivery. 2) Ensure transcribing ceases.

**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:**

Food services policies and procedures manual is in place. There is a qualified cook on duty each day supported by a morning and afternoon kitchen hand and kitchen assistant. There is a PSS four weekly menu that is reviewed by the company dietitian. Residents have input into the review of the menu. Variations to the menu are recorded. The cook receives a resident dietary requirements form with all new admissions and is notified of any dietary changes and weight loss. Resident dislikes are known and alternative choices are offered. Dietary preferences are accommodated including gluten free, vegetarian and diabetic. Normal, soft, moulied and mince moist meals are provided. Meals are transported in hot boxes to the dining area and served from bain maries. End cooked food temperatures are recorded on each meal. Fridges and freezers are temperature monitored daily. Chilled goods and frozens are temperature monitored on delivery. The kitchen is well equipped with freezers, chillers (three), deep fryer, electric hobs, combi oven and bratt cooking pan. All equipment has been serviced December 2013. The dishwasher is checked by the chemical provider monthly. The dry goods are sealed, labelled and off the floor in the pantry and rotated weekly with the delivery of food items. All foods are dated in the chillers and freezers. Chemicals are stored in locked cupboard. Safety data sheets are available and chemical safety training provided as required. Personal protective equipment is readily available and staff are observed to be wearing hats, aprons and gloves. The service receives feedback directly from the residents, residents meetings, internal audits and resident satisfaction surveys. There is good communication between the food services and the clinical areas and the cooks are informed of any resident's dietary changes. D19.2 staff have been trained in safe food handling and hygiene NZQA units 167 and 168.

#### **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):** 90 (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:**

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemicals supplies are kept in a locked areas. There are safety data sheets and wall product charts in place. Chemical bottles have correct manufacturer labels. Infectious material is double bagged. Approved containers are used for the safe disposal of sharps. Staff have attended chemical safety education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.

### 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:**

The building holds a current building warrant of fitness which expires 31 October 2014. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The facility is divided into rest home and hospital wings. The physical environment with wide corridors and hand rails allow for easy access to communal areas and promotes independence for residents with mobility aids. There is a communal dining room and lounges for the rest home and hospital areas. There is a family room with coffee/tea making facilities.

The caretaker is newly appointed to the full time role in June 2014 and works between two PSS facilities and is available on call for urgent facilities matters. Duties include minor repairs and maintenance, external and internal building maintenance and any internal maintenance, cleaning duties and monthly checks such as hot water temperature monitoring and pager systems. The maintenance request book sighted evidences requests actioned and signed off. The grounds are tidy, well maintained and able to be accessed safely with wheelchairs. There is outdoor seating and shaded areas. Electrical equipment is tested and tagged due December 2014. Clinical equipment is calibrated annually on July 2014.

ARC D15.3; The seven care workers interviewed (three rest home and four hospital) stated that they have all the equipment referred to in the support plans necessary to provide care, including hoists and slings, pressure relieving mattresses and cushions, tilting shower chairs, transfer belts, slidy sams, weighing scales, wheelchairs, sensor mats, mobility aids, electric beds, gloves, aprons and masks.

**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:**

All hospital bedrooms are single (exception of 2 double rooms which would be used for a married couple). There are two double rooms in the rest home wing for couples. All bedrooms have ensuites. There are communal toilets located close to the communal areas. The ensuites and communal toilets have appropriate flooring and handrails. There are vacant/occupied signs and privacy locks. Call bells are available in all toilet/shower areas.

#### **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:**

All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. The hospital rooms are spacious enough to manoeuvre hosts and hospital level lounge chairs. There are wide doors that allow ambulance access. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirm their bedrooms are spacious and they can personalise them as desired.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The rest home has a dining area for the rest home and hospital wings. There is a communal activity lounge and smaller lounges in each wing with seating placed appropriately to allow for group and individual activities to occur. A family room is available for visitors with coffee/tea making facilities. Residents are observed safely moving

between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs.

**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:**

All personal clothing and small laundry items are laundered on site. All other linen is sent off-site to the laundry at the other PSS site in town. The on-site laundry is carried out by the cleaner on duty and care workers throughout the shifts. There is a defined clean and dirty area of the laundry. The laundry is well equipped and the machinery has been serviced. Adequate linen supplies are sighted. There are two cleaners on duty each day working seven hours each. The cleaner's cupboard containing chemicals is locked. Cleaner's trolleys are well equipped. All chemicals have manufacturer labels. Laundry and cleaning staff are observed to be wearing appropriate personal protective equipment when completing their duties. The environment on the day of audit is clean and tidy. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms. The service contracts commercial cleaners for carpets. There is a splash guard over the sluice tub in the sluice room. Protective clothing is readily available for use. Staff have attended chemical safety training and infection control education.

**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 D15.3j; D19.6

**Attainment and Risk:** FA

**Evidence:**

Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated January 2006). Fire evacuations are held six monthly and the last drill was completed 29 May 2014. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, two battery back up-generator is used for oxygen concentrators and the hot water), a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days. Hoists have battery backup. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner. 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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All bedrooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated with ceiling heating and maintained at a comfortable temperature with radiator heating that is individually thermostats controlled. Residents interviewed confirm the environment and the bedrooms are warm and comfortable.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised.

The service has one rest home resident who is currently using a bedrail as an enabler. There are 13 enablers in use in the hospital (eight bedrails, four lap belts and one tray table). There are three restraints in the hospital (one bedrails, one tray table and one gate). A monthly restraint and enabler register is maintained.

There is a restraint co-ordinator and restraint committee. The GP is involved in the consent process for enabler and restraint. Restraint minimisation is discussed at the staff and management meetings.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

## Standard 2.2.1: 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:**

A registered nurse has been in the role of restraint coordinator for 12 years. There is a job description for the restraint co-ordinator. She is supported by a restraints committee that includes an enrolled nurse from the rest home and an RN from the hospital. The restraint co-ordinator and committee are responsible for the approval of types of restraint and monitoring the use of restraints. The approved restraints (bedrails, lap belts, tray table and gate) are documented in the restraint policy. There is provision for emergency restraint following consent from family/whanau

Restraint authorisation and consent is in consultation/partnership with the resident (as appropriate) or whanau, the facility restraint coordinators and GP. Restraint education is included in the two yearly education programme (September 2013) and on orientation to the service for clinical staff. The service has a number of student nurses and a recent quality initiative is to include restraint orientation for the students.

### 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:**

Restraint assessments are undertaken by the restraint co-ordinator in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term support plan, resident/family discussions, RN and care worker observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the resident/family/whanau and GP. Three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three monthly evaluations.

All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly by the restraint coordinator and approval group. Each episode of restraint is monitored on the resident monitoring form at pre-determined intervals (as per the specific care plan) depending on individual risk to that resident. Monitoring for bedrails is documented in the progress notes as sighted. Enabler monitoring is documented into the resident progress notes. Care plans reviewed of three hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents' restraint assessment and as viewed in the resident progress notes for monitoring of bedrails.

### **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:** FA

**Evidence:**

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is a registered nurse with responsibility for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Restraint consent is in consultation/partnership with the resident (as appropriate) or whanau, restraint coordinator, restraint committee and GP. The restraint risk assessment identifies the impact on the resident's freedom and comfort required during the period of restraint. Families are informed of the risks associated with the use of restraint. The RN may apply restraint in the case of emergencies however the family/whanau are to be consulted and the restraints co-ordinators is notified as soon as practical.

Staff complete incident forms and report any accidents/incidents to the RN/restraint coordinator in regards to restraint use and these are discussed at the RN, staff and management meetings and corrective actions initiated. Staff document restraint episodes on monitoring forms and in progress notes. A restraint register is maintained. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. There is a specific care plan for enablers and restraint that includes the use of restraint, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. Risks known to be associated with the use of enablers and restraint are documented on the specific care plan.

#### **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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the restraint co-ordinator at least three monthly or earlier if required. The medical review includes restraint use. Families are included as part of this review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and approval committee. The restraint co-ordinator and restraint committee evaluate review all restraint and enabler processes formally six monthly.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Individual approved restraint is reviewed three monthly as part of the medical review, six monthly as part of the care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint coordinator and restraint committee at the six monthly committee meeting. Relevant Incident/accidents are reviewed by the restraint coordinator. Corrective actions are monitored. There is a monthly restraint co-ordinator report taken to the staff meeting, RN meeting and quality meeting. Issues/concerns are discussed at the meetings. Restraint use is linked to the clinical audit programme with a restraint compliance audits six monthly last conducted May 2014. The restraints co-ordinator regularly checks the monitoring forms and progress notes for compliance.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator. There is an implemented infection control programme that is linked into the quality management system. The infection control committee oversees the infection control programme and its review. The programme is reviewed annually. The facility has access to GPs, local Laboratory, the infection control and public health departments at the local DHB for advice. There are two monthly infection control meetings. The monthly quality meetings also include a discussion and reporting of infection control matters. Information from these meetings is passed on to the staff meetings.

#### 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 infection control committee is made up of a cross section of staff including a registered nurse, enrolled nurse/s, cleaner and care worker. The facility also has access to an infection control nurse specialist, public health and GP's.

### 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:**

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator and the infection control committee.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed appropriate IC training including attendance at a DHB infection control day in April 2014. The orientation package includes specific training around hand washing. The IC coordinator provides training both at orientation and ongoing. Training on infection control is included in as part of the compulsory study days (link 1.2.7). Resident education is expected to occur as part of providing daily cares, in addition the service has developed a residents infection control handbook that provides clear appropriate information about hand hygiene and cross infection.

### **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 quality meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Hand hygiene audits are included in the audit schedule (last completed April). 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.

Vickery Court had a suspected scabies outbreak in January (2014) resulting in all staff and residents being treated, and a norovirus outbreak in March (2014) that affected an estimated 52 residents and 26 staff.

**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.

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

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