

Ashwood Park Lifecare (2012) Limited

Current Status: 16 September 2014

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

General overview

Ashwood Park Lifecare Limited has had no major changes to their directorship or buildings since the last audit. Changes have occurred to the management team. On the day of this spot surveillance audit there were 118 residents (51 hospital, 47 rest home, 20 dementia) out of a total of 121 beds available. There are 11 studio rooms which have rest home level care residents all occupied on the day of audit.

They have made progress since the last audit and this was particularly noticeable in the care planning areas. At the last audit there were 12 areas that required improvement. Two of these continue to be areas for improvement related to quality management and medication management. Three further areas are identified at this audit related to human resource management, education and training and infection control monitoring.

Audit Summary as at 16 September 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 16 September 2014

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

Organisational Management as at 16 September 2014

| | | |
|---|--|---|
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
|---|--|---|

Continuum of Service Delivery as at 16 September 2014

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

Safe and Appropriate Environment as at 16 September 2014

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

Restraint Minimisation and Safe Practice as at 16 September 2014

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|---|--|--|
| 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. |
|---|--|--|

Infection Prevention and Control as at 16 September 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

| | |
|---|--|
| Legal entity name: | Ashwood Park Lifecare (2012) Limited |
| Certificate name: | Ashwood Park Lifecare (2012) Limited |
| Designated Auditing Agency: | The DAA Group Limited |
| Types of audit: | Surveillance Audit |
| Premises audited: | Ashwood Park Retirement Village |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 16 September 2014 End date: 16 September 2014 |
| Proposed changes to current services (if any): | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 118 |

Audit Team

| | | | | | |
|--------------------------|--------|----------------------------|----|-----------------------------|---|
| Lead Auditor | XXXXXX | Hours on site | 8 | Hours off site | 4 |
| Other Auditors | XXXXXX | Total hours on site | 16 | Total hours off site | 8 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | XXXXXX | | | Hours | 2 |

Sample Totals

| | | | | | |
|--|----|-----------------------------------|-----|--------------------------------------|----|
| Total audit hours on site | 24 | Total audit hours off site | 14 | Total audit hours | 38 |
| Number of residents interviewed | 8 | Number of staff interviewed | 18 | Number of managers interviewed | 2 |
| Number of residents' records reviewed | 16 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 32 | Total number of staff (headcount) | 120 | Number of relatives interviewed | 9 |
| 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 The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

| | | |
|----|---|-----|
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Tuesday, 7 October 2014

Executive Summary of Audit

General Overview

Ashwood Park Lifecare Limited has had no major changes to their directorship or buildings since the last audit. Changes have occurred to the management team. On the day of this spot surveillance audit there were 118 residents (51 hospital, 47 rest home, 20 dementia) out of a total of 121 beds available. There are 11 studio rooms which have rest home level care residents all occupied on the day of audit.

They have made progress since the last audit and this was particularly noticeable in the care planning areas. At the last audit there were 12 areas that required improvement. Two of these continue to be areas for improvement related to quality management and medication management. Three further areas are identified at this audit related to human resource management, education and training and infection control monitoring.

Outcome 1.1: Consumer Rights

Open disclosure is apparent in the event of an incident with family speaking highly of communication with them on an ongoing basis and they state they would be contacted if there were events related to their relative.

There are no residents requiring interpreter services. Policy directs staff to access this service and they are aware of the process.

Complaints are managed by the directors on site managers who have an open door policy and are around the facility daily speaking with residents and family members. Residents and family members are made aware of the complaints process on admission and forms to give feedback including complaints are available in the facility. A complaint register records complaints which shows the process is timely, action is taken when required and complainants are happy with results.

Outcome 1.2: Organisational Management

Governance is through four directors who meet quarterly or more frequently if required. Two directors are also the onsite managers. A business plan is in place and is reviewed by all directors. The plan informs a quality and risk management plan and there is an audit schedule. Aspects of risk and quality, including health and safety and adverse events, are overseen by a quality assurance manager and the assistant manager, both of whom are registered nurses (RNs). They provide a monthly report to the directors/managers and to a clinical management team. This meeting is where risk and quality data is shared and there is evidence of corrective action plans occurring when required. Staff meetings allow for the flow of quality information, issues and outcomes to staff. An area identified at the last audit relates to the analysis and evaluation of quality data as a whole and this remains an area that requires improvement.

Recruitment is undertaken by the director/manager and eight staff files reviewed show documentation of most aspects of recruitment, including police checking, however reference checking is not consistently occurring and this is an area that requires improvement. Health professionals

have current annual practising certificates and all RNs have current first aid certification. There is an orientation process and this covers all areas of training pertinent to residential and dementia care. The assistant manager is a trainer and follows up all staff to ensure they meet contractual requirements. A number of areas have been identified as core training requirements for annual update, however the documentation sighted shows that not all staff have completed this training and this is an area for improvement.

The assistant manager manages the roster and this is seen as being a robust process meeting the requirements of the provider's contract with the district health board and residents' needs.

Personal profile forms completed on admission to the facility include signatures and designation of the service provider addressing a previous required improvement.

Outcome 1.3: Continuum of Service Delivery

Admission agreements are completed at the time of admission to the facility, addressing a previous required improvement.

The RN completes the initial nursing assessments and the 'interRAI' assessment from which a detailed lifestyle plan is developed. There is evidence that residents' needs are assessed on admission by the multidisciplinary team. Regular reviews occur to ensure assessed needs are documented and service delivery is provided in a timely manner. This addresses previous required improvements.

Care staff are observed providing services in a respectful and dignified manner, which reflects the lifestyle plan content. Lifestyle plans detail the required support for service delivery, and are updated if progress changes addressing previous required improvements. This is supported in resident and family interviews. A general practitioner (GP) is interviewed during the audit and confirms the facility provides services in line with his treatment recommendations, that RN assessments are appropriate and he is notified in a timely manner of any issues that arise.

An activities programme, that includes a diversity of activities and involvement with the wider community is planned and implemented by the activities person, which meets the individual interests of each resident, addressing an area of required improvement.

Well defined medicine policies and procedures guide practice, however not all practices sighted are consistent with these documents. Improvements are required around the faxing of medication charts to GPs, medicine reconciliation records, medication prescribing, recording processes, administration processes and medicine reviews occurring every three months. Oversight of medication management is from an external pharmacist who undertakes a weekly stock take this addresses a previous required improvement, the pharmacist also undertake reconciliation of medications into the facility.

Meals are provided by an external provider. Menus are reviewed by a dietician as meeting nutritional guidelines for older people. Any special dietary requirements and need for feeding assistance or modified equipment is recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided. A previous area requiring improvement around dating of incoming and opened food has been addressed.

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|------------|--|---|------------------|
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There is data being collected related to all the key components of quality management system and analysis occurs at the audit reporting level and reporting to different committees. However, the analysis of the overall aggregated results comparison is yet to occur. | The organisation implement a process for the systematic analysis and evaluation of quality improvement data collected. | 180 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Of six staff files reviewed, only one has evidence of reference checks occurring. There is a form that the manager uses but this is not consistently completed. | Reference checking is documented in line with current good practice. | 180 |
| 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 | There is a plan for ongoing education which includes core competencies. On review of the register of attendance it is evidence that not all staff have completed their core competences for this year. Not all staff have completed an annual appraisal. | Staff undertake mandatory training as required by contract and organisational determined mandatory training. All staff undertake annual appraisals as required. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: | Consumers receive medicines in | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---------------------|---|-------------|---|--|------------------|
| | Medicine Management | a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | | | | |
| 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 Moderate | <p>The blister packs are reconciled into the facility by the RN and the pharmacy (tick sheet sighted) once per month, however the facility does not keep a record of errors that have occurred, this is retained by the pharmacy, and this requires improvement.</p> <p>Medication charts reviewed are faxed copies, and the original has not been updated within two working days as required in the Medicines Care Guidelines for Residential Aged Care.</p> <p>It is observed that medications administered at 11 am are sighted as prescribed for breakfast time, since July 2013. The blister pack has the medication XXXXX in the 11am blister. The prescription record has not been altered to reflect the correct time, and the error has not been identified during reconciliation.</p> <p>Well defined medicine policies and procedures guide practice, however not all practices sighted are consistent with these documents. Issues of concern are evident around medicine charts, recording processes and with some of the administration processes. Not all medicine records show that medicine reviews are occurring every three</p> | Medication management is implemented to ensure the safe prescribing, administration and reconciliation of medicines in line with guidelines and legislation. Demonstrate and provide evidence that the medicine management system is implemented and adhered to. | 90 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|----------------|----------------------------|--|------------|--|---|------------------|
| | | | | months. | | |
| HDS(IPC)S.2008 | Standard 3.5: Surveillance | Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | | | |
| HDS(IPC)S.2008 | Criterion 3.5.7 | Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | Specific trends are identified, for example an increase in UTIs with E.coli is discussed verbally with the hospital CNM, and recommendations are implemented, however the action taken is not reported at the CNM meetings, and this requires improvement. The report in the clinical nurse manager (CNM) meeting for increased UTIs states – ‘each unit handling this’. | Results of surveillance and specific recommendations are evaluated and reported to relevant personnel and management committees in a timely manner. | 180 |

Continuous Improvement (CI) Report

| Code | Name | Description | Attainment | Finding |
|------|------|-------------|------------|---------|
| | | | | |

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

The manager/director spoken with stated that open disclosure occurs within the organisation. There is an Open Disclosure policy sighted in the policy manual folder; this meets the requirements of the standard. The quality assurance manager spoken with has oversight of adverse events and confirmed open disclosure occurs. She gave a verbal account of a medication event and how open disclosure was part of the process with the resident. In review of two residents' charts where patients had incidents there is evidence of family members being informed of the event occurring.

In discussion with the directors/managers on the contract (A13.2) requirements around the charging for premium rooms they stated that residents are admitted to a room which is vacant at the time wither it is a standard or premium room. Residents admitted to a premium room would not be moved to a standard room when it became available. Subsidised residents are made aware of any premium room if available and may choose to move, if they wish, from a standard room.

Residents and family members spoken with stated that there is a good orientation process and ongoing communication, in line with contractual requirements.

The manager/director stated that there is presently no resident who requires translation services and she could not recall having to use translation services. However, there is a policy sighted which gives details of how to access an interpreter service and staff spoken with (quality assurance manager and assistant manager) know how to access translation services.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.13: 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:

The director/managers manage the complaints process. At interview they spoke of how they receive verbal complaints from residents; they are around the home on a daily basis and are visible to residents and have an open door policy for all to come and speak with them. A number of family members communicate from a distance via email and this is apparent in the complaints register. A few complaints arise from residents meetings which are facilitated by the activities staff, others are received by telephone or in letter format. Residents and their family members are given information on complaints as part of the admission process. Forms are available at the entrance to the facility to give feedback, compliments and complaints, and these are sighted at audit.

The director/manager keeps a complaints register which is viewed and shows that they meet the timeframes required by legislation, action is taken to address concerns and complaints are closed when the person agrees with the outcome. An example seen is of a complaint being made by a resident on how staff served their meals. This resulted in education to staff on meal serving, discussions with the patient by the clinical manager and the resident being happy with the response to their complaint.

The requirements of the contract are met.

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:

There is a Business Plan sighted as developed in 2012 and the directors/managers stated this is reviewed by the four directors, one of whom is an accountant. Also sighted is the Business Plan Review 2014 which goes to the business directors. The four directors meet quarterly or more frequently if an issue arises. The Business Plan contains the mission and vision for the organisation as well as the goals and objectives, quality policy statement and quality and risk plan and a corrective action process. Processes meet the requirement of the contract.

The directors/managers have owned and operated rest homes for eight years and are members of the Aged Care Association New Zealand (ACANZ) and the Retirement Village Association (RVA). They attend conferences, meetings of residential facilities in the area and receive newsletters from the associations of which they are members. The assistant manager is a RN with over ten years' experience in residential care and with a special interest in infection control. She has a job description which outlines her role and responsibilities.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The Business Plan identifies nine goals and objectives which translate into a quality and risk plan. This is confirmed by the director/manager spoken with. The quality and risk process is overseen by a quality assurance manager who has recently been appointed (one month ago) and works 35 hours a week. The quality and risk plan has four areas; consumer focused, provision of effective programmes, certification and contractual requirements and quality and risk, all with their own objectives broken down into areas. There is an audit schedule which has approximately four areas audited from the schedule each month. The areas relate to the requirements of the Standards and contractual requirements. Examples include manual handling, resident file audits and laundry. Templates for audit have been developed and the quality assurance manager distributes the templates to staff to complete and return to her for analysis. When the audit falls below the key performance indicator requirement a corrective action form is developed. Examples sighted included manual handling and hand hygiene with corrective actions including staff training being undertaken. The areas of health and safety and infection control are the responsibility of the assistant manager. There is a health and safety folder which contains, health and safety policies and procedures, audits and the hazard register for the organisation. The register is reviewed and updated as hazards are identified and by the risk rating given to the hazard. The quality assurance manager and assistant manager provide monthly reports to the director/manager and for the clinical management team meetings on the areas they are responsible for.

In discussion with the directors/managers it is evident that the quality improvement process is linked at the weekly clinical team meetings. The template used for these meetings (sighted), brings together the elements of quality and risk management and a corrective action process is under taken and documented at these meetings. Corrective actions are undertaken at a number of levels and this is appropriate. However it is recommended that the number of corrective action forms in use be reviewed. Also the organisation identify which form meets the requirements of the organisation to allow for a clear flow of information collected, actions and completion data to allow for a complete picture for major corrective actions.

It is evident that quality and risk information is also taken to appropriate staff meetings, such as the RN and EN meeting, health and safety meeting, full staff meeting and infection control meeting.

The organisation has three hard copy manuals that are available to all staff. Document control is detailed at the bottom of the policies. At interview the quality assurance manager provided evidence of the audit schedule that includes updating of policies. The policies have been developed by an external consultant and they receive updates when required. These are seen to be in line with current good practice and legislative requirements. Policies are seen that meet the requirement of the contract.

An area requiring improvement identified at the last audit related to ensuring the quality improvement data collected is reviewed, analysed and evaluated. The previous quality assurance manager has put together an annual report which detailed the audits undertaken; however, there is no analysis or evaluation of the core data to identify trends for areas of risk and this remains an area for improvement.

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:

There is evidence in the Quality and Risk Plan of an audit plan which covers areas appropriate for the organisation. There are three to four audits carried out by staff of the different areas each month; examples are hand hygiene, manual handling and policies and procedure reviews. Once the templates are completed they are analysed by the

quality assurance manager and if they fall below the desired level identified in the key performance indicator document then a corrective action plan is generated. Monthly reports on the audits completed and analysis are reported to the directors and at the clinical manager's team meeting. The health and safety and infection control reports detail analysis and trending. However there is no overall analysis and evaluation of the results of the data collected, including complaints, incidents, hazard, and infections over time, to identify areas of risk for the organisation.

Finding:

There is data being collected related to all the key components of quality management system and analysis occurs at the audit reporting level and reporting to different committees. However, the analysis of the overall aggregated results comparison is yet to occur.

Corrective Action:

The organisation implement a process for the systematic analysis and evaluation of quality improvement data collected.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The quality assurance manager and assistant manager are able to identify areas that are required to be reported to other statutory bodies, such as the Ministry of Health, DHB, and professional bodies. The recent Norovirus outbreak was reported appropriately.

The organisation has an adverse event reporting process (Flash Reports) which is paper based and is known to staff spoken with (two healthcare assistants (HCAs) and two clinical nurse managers). The documented process meets the requirements of the contract. The assistant manager collects any reports on a daily basis and will review for any action plan requirements. A register of adverse events is kept and incidents are included in the monthly report to the director/manager and to the clinical management

team meeting and other meetings as appropriate. The register of incidents is sighted and it shows what actions have been taken. Areas identified as frequent incidents include falls and medication errors. Education of staff on these areas has been undertaken as part of the corrective action process.

The process meets the requirements of the contract.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: PA Low

Evidence:

The organisation has a spreadsheet which identifies all health practitioners' annual practising certificates, including RNs, EN, doctors, pharmacists, podiatrists and physiotherapists. This shows all are current and this is verified by in one RN file which has a copy of their annual practising certificate.

The directors/managers undertake the human resources management processes. They are able to state their practice for recruitment, and six staff files (two RN, three HCA, a diversional therapist) are reviewed which show the process as stated. The files show documentation of application form, curriculum vitae, job description, Inland Revenue Department documents, professional qualifications and police checking. However, in seven out of eight files reviewed there is no documented evidence of reference checking occurring and this is an area for improvement.

Orientation of new staff occurs and this is evidenced by sighting an orientation booklet which is completed and signed off by the assistant manager. The booklet covers all areas expected of a residential facility. The assistant manager at interview spoke of the process which lasts as long as is required to ensure safe practice (usually three to four days), she is able to give an example of an extended time frame for one new staff member who was having difficulty due to expectations in personnel cares being different to that of her native country. New staff members are 'buddied' with another staff member during their orientation to complete the orientation booklet. The orientation process is confirmed by a HCA spoken with.

The quality assurance manager and assistant manager interviewed spoke of the ongoing training which covers areas based on the standard and contract requirements. The calendar for 2014 is seen and includes, abuse and neglect, the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), cultural competency, safe handling and challenging behaviour. A spreadsheet is kept of all staff who have completed their annual competency training and shows that not all staff have completed these requirements. The assistant manager is a Careerforce trainer and provided evidence of care staffing having undertaken appropriate levels of training for their areas of work as per contract requirements. Staff working in the dementia area have appropriate training. (See 1.3.3)

Eight RNs are currently undertaking a professional development and recognition programme (PDRP) process in line with the DHB programme, whose training schedule the staff can access. There is a process for annual appraisals and these are recorded on a spreadsheet. This is seen as not being current and is an area requiring improvement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The appointment of service providers is undertaken by the directors/managers. At interview they are able to state the process used which is in line with current good practice. There have been a number of new staff employed and file review is undertaken of five recent appointed staff and a further staff member. They show the process stated is being followed with documentation in the files including application forms and police checks occurring and information for IRD purposes. However, there is only one file that contains a documented reference check.

Finding:

Of six staff files reviewed, only one has evidence of reference checks occurring. There is a form that the manager uses but this is not consistently completed.

Corrective Action:

Reference checking is documented in line with current good practice.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a system for the identification and planning of ongoing education for staff. The quality assurance manager and assistant manager spoke of how this is developed with input from staff and the requirements of the standard and contract. A calendar is developed annually and includes mandatory training on a list of core competencies. Attendance at the training is recorded and put onto a spreadsheet. On review of the spreadsheet it is apparent that not all staff have completed their mandatory training for 2014.

Staff have annual appraisals and a list of when these are due are recorded on a spreadsheet with the quality assurance manager sending out reminders. The spreadsheet shows that not all staff have undertaken their annual appraisal.

Finding:

There is a plan for ongoing education which includes core competencies. On review of the register of attendance it is evidence that not all staff have completed their core competences for this year. Not all staff have completed an annual appraisal.

Corrective Action:

Staff undertake mandatory training as required by contract and organisational determined mandatory training. All staff undertake annual appraisals as required.

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 duty rosters for each area are developed by the assistant manager. These are usually completed six to eight weeks in advance. Staff may request changes and these would be signed off by the duty manager. The duty rosters for all areas are reviewed and show staff working varying hours to meet the high need times of the different areas, such as activities people working later in the day to allow for 'sundowner' behaviours. These show cover by a RN and meet the requirement of the contract. Monday to Friday there is a clinical manager supported by a further RN in the dementia and rest home areas. Staff are also assigned to the studio apartments and have oversight of a RN. This is confirmed by a HCA and the quality assurance manager who provides the RN oversight on some duties.

The assistant manager and clinical managers are on call after hours and weekend and this is indicated on the roster.

There are two activities staff, one has one paper outstanding for her diversional therapy certificate and is mentored by other local diversional therapists.

There are three casual staff who have been orientated to work in all three areas.

Cleaning, laundry and kitchen staff are rostered on daily, a 'tea person' (two) assist with the evening meals and staff on night duty carry out extra duties such as cleaning, laundry and breakfast preparation.

Staff spoken with report that staffing is at a 'good level'.

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:

A previous corrective action has been addressed. Personal profile forms on admission to the facility are completed, with a signature and designation of the person who has completed the form, as verified in files reviewed (five of five hospital, five of five rest home and four of four dementia unit residents).

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.)*

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:

Hospital wing: Admission agreements are reviewed in seven of seven files. All those reviewed are completed on the day of admission to the facility meeting ARRC D13.1 requirements.

Rest Home and Dementia Unit: A previous correction action identified admission agreements not signed and this has been addressed. Admission agreements sighted for the dementia unit and rest home are signed and sighted in each of the files reviewed (four of four dementia unit residents and five of five rest home residents).

The ARRC contract requirements are met

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 1.3.3: 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:

Each stage of the service provision is undertaken by suitably qualified providers and is developed with the resident and their family/whanau. Care plans are developed within required timeframes and are based on the Needs Assessment and Service Coordination (NASC) assessment and/or previous provider of personal care services, general practitioner (GP), and registered nurse (RN) assessments. Information is also gathered from the resident, their family/nominated representative. The facility utilises a hardcopy format for residents' lifestyle plans. The long term lifestyle plan includes identified needs, goals and timeframes, interventions and evaluations in all service areas, including personal care needs, skin care, elimination, respiration, cardiovascular, sleeping, communication and sensory, mobility, pain and comfort, safety, social needs, sexuality, cultural and spiritual needs, nutrition, continence and behaviour needs.

A short term care plan has been developed if required for wounds, chest or urinary infections, and mobility issues, and is identified in the integrated notes on a separate form.

Progress notes, recording the daily progress of the resident are documented by the care staff providing the care, and the RN (where RN input is required) each shift.

The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents' needs change. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents' desired outcomes are being met. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident's medication is reviewed three monthly or as needs change and this is conducted by the resident's GP.

The facility has several (35) GPs that visit the facility. One GP is interviewed and confirms the facility provides a good level of care and assessments are appropriate. He is advised by fax of residents' needs prior to any visit, and is also available as required after hours. Clinical files reviewed include an exemption from the GP if the resident is clinically stable to require three monthly reviews, addressing a previous required improvement.

Hospital wing: Seven of seven hospital residents' files are reviewed. The number has been extended to provide conformity, as not all have used the electronic interRAI assessment process. All files reviewed have a NASC and/or the interRAI assessment completed prior to admission to the facility. The interRAI assessment is accessed via the electronic database 'Momentum' (sighted).

Discussion with the Clinical Nurse Manager (CNM), RN, EN one care staff and observation during the audit provides evidence that consultation with the RN relating to service provision occurs regularly. Interview with one care staff in the hospital verifies that services provided reflect the RN's directions and the lifestyle plan content. There is

sufficient detail in the lifestyle plans reviewed to guide care staff in all areas. The hospital wing has commenced a trial of a new format for progress notes with a heading for comment in PC (personal care), mobilisation, diet, eliminate, social/behaviour/other.

Family members interviewed confirm that contact with them occurs regularly, either verbally on site or by phone. Family contact is recorded in the residents' progress notes and on the family contact form (records sighted). There is evidence of other health professionals involved in the residents' care. For example, dietitian, podiatrist, and physiotherapist with recommendations documented in the integrated notes.

Rest Home and Dementia Unit:

Family contact is documented in the progress notes. Evidence of this is sighted in files reviewed and verified by interview (five of five rest home residents, three of three rest home family members and three of three dementia residents' family members). Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews.

Registered nurses practicing certificates, medication competencies, training records and first aid certificates are sighted. The RN acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care.

Caregivers with experience, education and training in aged care and dementia (as evidenced by training records) provide most of the direct provision of care. Caregivers in the dementia unit have or are in the process of completing the dementia training, in addition to some attending the monthly dementia training workshops "walking in another's shoes" modules provided by the CDHB

The cooks and kitchen assistants have qualifications in food safety training.

The contracted podiatrist provides services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

Each RN working in the dementia unit or the rest home, oversees the residents whose care they are responsible for planning. Residents are attended to by their GP of choice

A verbal handover by an RN or team leader occurs at the beginning of each shift (observed), in the rest home and dementia unit, to ensure all staff is familiar with the resident needs.

Health professionals are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift.

Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in resident's files, where specialist input is required.

The ARRC contract requirements are met.

Tracer 1 Hospital –

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

Tracer 2 – dementia unit resident:

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

Tracer 3 – Rest home resident:

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

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

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

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 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.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 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.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> |
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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:

Hospital Wing: Seven of seven care plans are reviewed. Detailed and individualised goals have been developed for each service section following an assessment. The hospital clinical nurse manager (CNM) interviewed confirms the use of the interRAI assessment as an initial assessment. These results, and those of other assessment tools (eg, a falls risk assessment, a pressure area risk, and (if relevant) a pain assessment) are completed, and the findings are included and used to identify measurable goals for each resident. Family and residents interviewed verify that the CNM and RNs involve them in the assessment process. The ARRC requirements D16.2 are met.

Rest Home and Dementia Unit: A previous corrective action request relating to assessments not routinely being completed when progress is less than expected has been addressed. The assessments, in the dementia unit and rest home at Ashwood Park Lifecare are reviewed six monthly and when progress is less than expected as needs, outcomes and goals of the resident change. In addition, the dementia unit uses a 24 hour activity plan which includes identification of a range of needs, interests, group activity involvement and individual activities plan which is completed by the activities staff. This document identifies residents' need over the 24 hour period and detail interventions linked to meeting those needs. This document is reflective of each resident's need over the 24 hour timeframe in relation to individual diversional, motivational and recreational therapy and addresses a 24 hour plan of care, including behaviour management to guide activities and care staff on how to support individual residents.

Evidence of this is sighted in dementia unit and rest home files reviewed. Resident and family interviews, verify they are included and informed of all assessment updates and changes. Dementia unit and rest home clinical staff (two of two RNs and six of six caregivers) interviewed confirm they use the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.

The ARRC requirements are met.

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:

Hospital wing: Seven residents' lifestyle plans are reviewed including T1. The initial interim lifestyle plan is developed following an interRAI assessment, RN assessments and within timeframes to safely meet the resident's needs. The long term lifestyle care plan is developed within three weeks of admission (records sighted including old notes). When progress alters, the RN or CNM (both interviewed) will develop a short term care plan, using appropriate assessment tools as verified in documentation sighted.

There is evidence of integration from allied health in the care plans sighted. For example, T1 requires input from an OT to assist with functioning. The OT's recommendations are included in the interventions in the lifestyle plan. One of one care staff interviewed confirms the lifestyle plans are easy to follow and is able to describe interventions for T1 reflective of the care plan. Care staff and the RN and CNM are observed in discussion at regular intervals with care staff, and referring to the residents' integrated notes.

The relevant ARRC requirements are met.

Rest Home and Dementia Unit: A previous correction action request relating to care plans in the dementia wing not being updated when the care plan is reviewed has been addressed. Care plans in the dementia unit are evaluated six monthly or more frequently as the resident's condition dictates. The dementia unit uses a 24 hour activity plan which includes identification of a range of needs, interests, group activity involvement and individual activities plan which is completed by the activities staff and identifies need over the 24 hour period and detail interventions linked to that need. This document is reflective of resident need over the 24 hour timeframe in relation to individual diversional, motivational and recreational therapy and addresses a 24 hour plan of care, including behaviour management and guides activities and care staff on how to support individual residents to reduce challenging behaviours.

Short term care plans, document the existence of short term problems and the required intervention.

Information from the assessment process informs the allied services of resident need. The kitchen is informed of need regarding nutrition, activity assessments inform the activities officer of interventions required in the activities programme and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need. Evidence of this is sighted in files reviewed. Resident and family interviews, verify they are included in the planning of their/their family member's care.

The ARRC requirements are met.

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.)*

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

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

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

Attainment and Risk: FA

Evidence:

Hospital wing: The CNM or the RN (both interviewed) document appropriate interventions on the resident's short term or lifestyle care plan. Those sighted are consistent with meeting the resident's identified outcomes, are evaluated regularly and the care plan is either updated or a short term care plan is developed. Progress notes are written by care staff and those sighted confirm residents' needs are met and service delivery is provided in a timely manner. Staff are observed providing care to residents, for example T1's nutritional needs, reflective of the resident's care plan.

GP assessments sighted are detailed in the appropriate clinical form in the integrated resident's file and the subsequent intervention (eg, antibiotics for a chest infection and increased medication for peripheral oedema (T1)) are observed as included on the resident's short term care plan.

Residents (three of three) and family members (three of three) interviewed confirm service delivery is consistent with meeting the residents' desired outcomes and they are involved in the review process, as evidenced in the family communication form and residents' MDT team meetings (records sighted). The care and services at Ashwood Park Lifecare are delivered in a safe and respectful manner.

Rest Home and Dementia Unit: The provision of care in the rest home and dementia unit is consistent with the desired outcomes in residents' files reviewed which document the residents' physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.

Interviews with residents and family/whanau members expressed satisfaction with the care provided and verify new residents are welcomed and orientated to the facility.

There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident's needs (sighted).

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is evidence of individual residents activity plans are based on assessment of residents' interest and past activities with input from the resident and their family members. This results in goals that are reviewed six monthly to ensure they remain current. Monthly activity programmes are developed and seen as appropriated for each specific area with evidence of individual activities being undertaken with those residents who do not wish to participate in group activities.

Hospital wing: The activities person is interviewed and five of five activity plans are reviewed. A social profile is completed by the activities person in consultation with the resident and family member on admission to the facility (records sighted). The information is included to develop the activity plan. Activity plans reviewed are detailed and include goals and interventions that are individualised and reflective of realistic outcomes.

.Rest Home and Dementia Unit: A previous correction action around activity plans in the dementia unit and the rest home has been addressed. Activity plans reviewed in the dementia unit and rest home are specific to the resident's interests and past activities and include a summary of progress that the resident has attended activities.

Activities reflect ordinary patterns of life and include normal community activities (eg, bus outings, visiting entertainers, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.

A monthly summary of the resident's response to the activities, level of interest and participation is recorded. The activities co-ordinator interviewed reports feedback is sought from residents during and after activities.

The dementia unit has an activities programme operating every day, by two activity co-ordinators who are being mentored by an offsite diversional therapist, until the hospital diversional therapist completes her final paper and can oversee them. One of the activities co-ordinators has just completed "walking in another persons' shoes" dementia training modules offered by the Canterbury District Health Board (CDHB)

Interviews verify residents and family are satisfied with the activities offered.

The ARRC requirements are met.

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:

Hospital wing: The CNM and RN are interviewed and seven residents' files reviewed are evaluated at least six monthly in line with requirements (records sighted). Mobility, continence, pain, and self-care assessments are completed prior to the review of the lifestyle plan and the assessment content reflects the updated lifestyle plan. There is evidence that lifestyle plans are evaluated if progress is less than expected using appropriate assessment tools. And a short term plan is developed indicative of the residents' changed needs. T1's records sighted include short term care plans reflective of their changed needs and evaluations are included following resolution of these. The previous required improvement has been addressed

Residents and family members interviewed verify they are included in care plan evaluations as part of the MDT process (records sighted) and there is evidence of this documented in the residents' integrated notes (sighted). Care staff interviewed are able to demonstrate knowledge in following short term care plans when needs change.

Rest Home and Dementia Unit: A previous corrective action that identified when progress is not as expected the long or short term care plan is not updated or developed to reflect the change has been addressed. Evaluation of resident care in the dementia unit and the rest home is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN who may contact the GP if requested. Family/whanau are kept informed of changes. Where progress is different from expected or a resident is not responding changes are documented in the care plan. A short term care plan is initiated for short term concerns such as infections, wound care, changes in mobility and the resident's general condition.

The RN undertakes and documents all care plan evaluations, at least every six months. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Evidence of evaluation is sighted in files reviewed. Resident and family interviews verify they are included and informed of all care plan updates and changes.

The ARRC requirements D16.3c; D16.3d; D16.4a are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The organisation has a blister pack medication system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the RN and the pharmacy (tick sheet sighted) once per month, however the facility does not keep a record of errors that have occurred, this is retained by the pharmacy, and this requires improvement. Discontinued medications are returned to the pharmacy at least daily if required, including controlled medications (records signed by the RN are sighted).

The resident's prescription medication record is completed by the resident's GP, and administered by the facility care staff. A previous corrective action around medication signing and dating has been addressed. The medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented as verified by medicine charts reviewed (fourteen hospital, ten rest home and eight dementia unit residents). However, four of fourteen medication charts in the hospital and two of ten in the rest home reviewed are faxed copies, and the original has not been updated within two working days as required and this is an area that requires improvement.

The medication trolley holds all current medication, blister packs and medication records and is locked when not in use and stored in the key pad secured medication room.

There is a separate medication fridge, and temperatures are recorded (observed) and within recommended guidelines.

An enrolled nurse (EN) is observed administering medications on the day of the audit. It was observed in the hospital wing and rest home that residents with XXXXX prescribed to be given at 7.00am, yet sighted documentation indicates it is packed, dispensed and signed for as given at 11.00am. The prescription record has not been altered to reflect the administration time. There is no evidence that this has been identified during reconciliation of incoming medications. This is an area identified as requiring improvement.

There are no residents who self-medicate in the hospital wing and two of two residents who self-administer their medicines in the rest home at the time of audit. The sighted assessments for self-administration is sighted in the residents' files reviewed and meet the facilities policy.

Controlled drugs are reviewed and storage is in line with guidelines. Controlled drugs, when dispensed are checked by two medication competent nurses (one an RN) for accuracy in dispensing. A previous corrective action that found no physical check of XXXXX occurring in the dementia unit has been addressed. The controlled drug register in the rest home and dementia unit evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded.

The nurse educator monitors to ensure all staff who administer medications have current competencies.

RNs are assessed for medication competency yearly and approved senior healthcare workers are certified as competent in Medication Administration (documentation sighted), under the direction and delegation of a RN.

Standing orders are not used at Ashwood Park Lifecare.

The relevant ARRC requirements are met.

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 Moderate

Evidence:

The organisation has a blister pack medication system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the RN and the pharmacy (tick sheet sighted) once per month, however the facility does not keep a record of errors that have occurred, this is retained by the pharmacy, and this requires improvement.

The resident's prescription medication record is completed by the resident's GP, and administered by the enrolled nurse (EN) or RN. The record is overall legible and signed individually by the GP including when discontinued. However, four of fourteen medication charts in the hospital wing and two out of two in the rest home medication charts reviewed are faxed copies, and the original has not been updated within two working days as required and this needs addressing.

It was observed in the hospital wing and rest home that residents with XXXXXX prescribed to be given at 7.00am, yet sighted documentation indicates it is packed, dispensed and signed for as given at 11.00am. The prescription record has not been altered to reflect the administration time. There is no evidence that this has been identified during reconciliation of incoming medications..

All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. However, not all medicine records show that medicine reviews are occurring every three months.

Finding:

The blister packs are reconciled into the facility by the RN and the pharmacy (tick sheet sighted) once per month, however the facility does not keep a record of errors that have occurred, this is retained by the pharmacy, and this requires improvement.

Medication charts reviewed are faxed copies, and the original has not been updated within two working days as required in the Medicines Care Guidelines for Residential Aged Care.

It is observed that medications administered at 11 am are sighted as prescribed for breakfast time, since July 2013. The blister pack has the medication XXXXX in the 11am blister. The prescription record has not been altered to reflect the correct time, and the error has not been identified during reconciliation.

Well defined medicine policies and procedures guide practice, however not all practices sighted are consistent with these documents. Issues of concern are evident around medicine charts, recording processes and with some of the administration processes. Not all medicine records show that medicine reviews are occurring every three months.

Corrective Action:

Medication management is implemented to ensure the safe prescribing, administration and reconciliation of medicines in line with guidelines and legislation.

Demonstrate and provide evidence that the medicine management system is implemented and adhered to.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food, fluid and nutritional requirements of the residents at Ashwood Park Lifecare is provided by an external provider in line with recognised nutritional guidelines for older people as verified by the dietitians documented assessment of the planned menu, that changes seasonally (sighted).

A previous corrective action identified not all incoming or opened food is dated and there is no indication that the storage bins are washed and clean. Two 'pig buckets' are located in close proximity and not clean, half full and attracting flies. These areas have been addressed.

Training records verify the cook and kitchen staff are trained in food and hygiene safety.

Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the resident's recommended nutritional requirements. Between meal snacks are available at all times in the dementia unit, as sighted and verified by resident, staff and family/whanau interview.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs are sighted.

Evidence of dementia and rest home resident satisfaction with meals is verified by residents and family/whanau interviews.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed, as sighted and on the roster reviewed. The dining rooms are clean, warm, light and airy to enhance the eating experience

Food is ordered by the cook on a weekly basis. Fresh fruit and prepared vegetables are ordered every one to two days depending on need and availability and meats and fish are ordered as required. When food is delivered it is checked for 'use by date' and damage, dated, then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers or opened food is covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC requirements are met.

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.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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 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.

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| <p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <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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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:

Areas for improvement were identified at the last audit related to the storage of chemicals in an unlocked garage and in the utility rooms and the monitoring of electrical equipment. A tour of the facility identified that bulk chemicals are stored in a locked sign posted room outside the main building and the garage where paint and garden chemicals are stored is locked. The areas where chemicals are kept visited are utility rooms, these have key pad entry and a kitchen in the rest home area has child protection locks which do not allow ease of access to stored chemicals.

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 director/manager provided a copy of the current building warrant of fitness; this is sighted as expiring in February 2015. There have been no changes to the buildings since the last audit.

The director/manager provided evidence of a four monthly visit by external contracted services to oversee the maintenance of equipment within the facility. This is sighted for the last month and includes sanitisers and other equipment. On a tour of the facility a sample of electrical equipment including, electric beds, televisions and sanitisers are seen as having current maintenance certificates. It is recommended that the facility have a copy of the list of equipment that is being maintained which is easily accessed.

The facility meets the requirements of the contract.

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.)*

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

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

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

Attainment and Risk: Not Audited

Evidence:

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.)*

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

As confirmed by the restraint coordinator and verified by staff interviews the use of enablers is voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Residents who use enablers have them in place to allow them to maintain maximum independence. Residents using enablers at Ashwood Park Lifecare are mentally alert and can ask for assistance appropriately. Enablers are monitored and reviewed as per restraints for the purpose of review and signing updates. This is confirmed in hospital files reviewed of residents using enablers. Enablers in use are bedside rails to help resident's move around the bed independently and a chair lap belt when using the chair or wheelchair. Discussions with the family/whanau, the GP and the restraint coordinator are clearly documented.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

A previous corrective action identified around advocacy and support offered to residents who are assessed as needing restraint not being evidenced, has now been addressed. Consent for restraint, now routinely includes an offer of support and/or advocacy services, as verified by interview with the restraint co-ordinator and resident/family plus restraint documentation in the files reviewed of residents requiring restraint.

The ARRC requirements are met

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.)

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

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

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

Attainment and Risk: PA Low

Evidence:

The infection control (IC) nurse collects data on all infections on a daily basis and develops a monthly report of all infections. The report is provided to each area – hospital, dementia and rest home wings. Specific trends are identified, for example an increase in urinary tract infections (UTIs) with E.coli is discussed verbally with the hospital CNM, and recommendations are implemented, however the action taken is not reported at the CNM meetings, and this requires improvement. The report in the CNM meeting for increased UTIs states – ‘each unit handling this’.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The infection control (IC) nurse collects data on all infections on a daily basis, and develops a monthly report of all infections. The report is provided to each area – hospital, dementia and rest home wings. Specific trends are identified, for example an increase in UTIs with E.coli is discussed verbally with the hospital CNM, and recommendations are implemented, however the action taken is not reported at the CNM meetings. The report in the CNM meeting for increased UTIs states – ‘each unit handling this’.

Finding:

Specific trends are identified, for example an increase in UTIs with E.coli is discussed verbally with the hospital CNM, and recommendations are implemented, however the action taken is not reported at the CNM meetings, and this requires improvement. The report in the CNM meeting for increased UTIs states – ‘each unit handling this’.

Corrective Action:

Results of surveillance and specific recommendations are evaluated and reported to relevant personnel and management committees in a timely manner.

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