# The O'Conor Institute Trust Board

## Current Status: 24 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

The O’Conor Memorial Home has provided rest home and hospital care for residents in Westport for many years and since the last certification audit has commenced the provision of dementia care. The total available beds in this facility is now 53.

There have not been any significant changes in the operation of the service, nor in the quality management systems since the certification audit; however the building upgrade and earthquake strengthening has been completed and the building for the additional beds completed.

This unannounced surveillance visit confirms that twelve of the thirteen areas that were identified as requiring improvement during the certification audit have been addressed. The outstanding area for improvement relates to the need for identified short term problems to be transferred into short term care plans, which continues to require attention. A new area requiring improvement is the need for staff performance appraisals to be maintained.

## Audit Summary as at 24 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 |
|  | 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 24 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 24 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 24 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 24 September 2014

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

### Restraint Minimisation and Safe Practice as at 24 September 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 24 September 2014

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

# 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:** | The O'Conor Institute Trust Board |
| **Certificate name:** | The O'Conor Institute Trust Board |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | The O'Conor Memorial Home | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 24 September 2014 | **End date:** | 24 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:** | 46 |

## **Audit Team**

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

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 10 | Total audit hours | 26 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 46 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, 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 Monday, 6 October 2014

## **Executive Summary of Audit**

**General Overview**

The O’Conor Memorial Home has provided rest home and hospital care for residents in Westport for many years and since the last certification audit has commenced the provision of dementia care. The total available beds in this facility are now 53.

There have not been any significant changes in the operation of the service, nor in the quality management systems since the certification audit; however the building upgrade and earthquake strengthening has been completed and the building for the additional beds completed.

This unannounced surveillance visit confirms that twelve of the thirteen areas that were identified as requiring improvement during the certification audit have been addressed. The outstanding area for improvement relates to the need for identified short term problems to be transferred into short term care plans, which continues to require attention. A new area requiring improvement is the need for staff performance appraisals to be maintained.

**Outcome 1.1: Consumer Rights**

Open disclosure processes are being implemented according to the policies and procedures on the issue. There is open communication occurring between staff and residents and family members for all aspects of their care, especially following an adverse event. An interpreter service is accessible through the local district health board; however this has not been required to date.

An area requiring improvement relating to the signing of consent forms and advanced directives has been addressed with all sighted now signed.

A complaints policy and procedure meets the requirements of Right 10 of the Code of Health and Disability Services Consumers Rights. Staff are familiar with how to accept a complaint and where forms and brochures on the topic are held. Written and verbal complaints are being investigated and resolved and a complaints register provides an overview of the nature of complaints, the people involved and how and when different stages of resolution occurred.

**Outcome 1.2: Organisational Management**

A mission statement, a service based philosophy and goals within a business plan and a quality plan all focus on the residents, their needs, independence, family and community and staff development. The general manager and quality manager provide leadership with ongoing accountability to a Trust Board committee.

The O’Conor Memorial Home is demonstrating an ongoing commitment to the implementation of their quality management system. Key issues for quality management are discussed at quality assurance meetings every two to three months. Regular meetings with different staff groups and with the residents ensure the information filters through the organisation. Systems that ensure policies and procedures remain current are in place. The quality management reports and documents cover reportable events (including complaints), internal audits, restraint/enabler use, infections, risk management, health and safety, review of the hazard register, corrective actions and quality improvement opportunities. The hazard register now includes hot water temperature monitoring, which addresses a previous required improvement.

Professional qualifications of those associated with the service are checked, recruitment processes ensure new employees are suitable and a comprehensive orientation programme is provided. Staff are supported to participate in both external and internal training opportunities and records of these are available. An area requiring improvement is that annual performance appraisals are kept updated.

The manager ensures staffing levels are safe and meet the needs of the residents and this is evident in staff rosters and in reports from those interviewed.

A register of staff signatures and designations is in place. Residents’ records include these and are dated, which addresses an area that required improvement from the certification audit.

**Outcome 1.3: Continuum of Service Delivery**

Resident care is overseen by a nurse manager and provided by registered nurses and caregivers. There is a registered nurse on site 24 hours a day, seven days a week. A general practitioner visits the facility fortnightly and as required.

Entry to the facility occurs following a needs assessment, completion of an O’Conor Memorial Home interview and assessment form, and signed acceptance of the admission agreement. The admission agreement contains all criteria required in the provider’s agreement with the district health board, which addresses an improvement required from the previous audit.

On the day of entry an initial care plan is developed. The long term care plan is written within the following three weeks after completion of several supplementary assessments and written observation by care staff. All sections of the care plan are signed and dated by the registered nurse and resident/family confirming resident involvement. Care plans reviewed display a commitment to providing appropriate and timely care which is monitored and evaluated as required. The three previous required improvements relating to the signing of the care plans, timely care planning and evaluation have been addressed.

Short term care plans were an area identified as requiring improvement at the previous audit and still require further work. Short term problems need to be written into the resident’s service delivery plan and filed in their personal folder.

The activities programme is overseen by a qualified diversional therapist and includes individual, group and community activities. Residents spoken with state their satisfaction with the activities programme and their ability to freely visit their relatives who live outside of O’Conor Home.

Medications are prescribed by a qualified medical practitioner and dispensed by a qualified pharmacist. The medications are stored in a locked cupboard in a locked room reflecting safe practice guidelines and legislative requirements. Residents receive their medications in a safe and timely manner. A previous area for improvement relating to crushed medications has been addressed with written approval being given by either the pharmacist or general practitioner, where applicable.

The menu is developed under the guidance of a qualified dietitian. Both cooks are trained in safe food handling and kitchen processes are observed to be consistent with providing safe and nutritious meals. Each resident has an individual nutritional profile developed on admission and reviewed as required. Staff are observed delivering food and fluids to residents to meet their individual nutritional needs and preferences.

Comments from the three residents spoken with reflect a general satisfaction with living in the home and the service received.

**Outcome 1.4: Safe and Appropriate Environment**

The O’Conor Memorial home has a current Code of Compliance certificate following an upgrade to older buildings and the building of a new wing.

A maintenance register is being maintained and work is being dated and signed off when completed. There is a fire service letter of approval of the evacuation plan available that meets the requirements.

A smoking room at this facility has been replaced by a designated outdoor area for those who choose to smoke. This change, which reduces the exposure of residents who do not smoke to cigarette smoke fumes, the signing off of repair and maintenance work and the availability of the Code of Compliance and the fire service approval letter all contribute to addressing the areas that required improvement in the previous certification and partial provisional audits.

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

Bed rails, a lap belt and a fall out chair are the enablers that are currently in use at this facility. Assessments have been made and residents using this equipment have provided consent for its use. The voluntary use of enablers is clearly described in the restraint minimisation and safe practice policy and procedure documentation and staff are familiar with the difference between a restraint and an enabler. No form of restraint is used in the O’Conor Memorial Home.

**Outcome 3: Infection Prevention and Control**

An infection prevention and control surveillance programme is in place. A range of infections have been identified for inclusion in the programme and records are being made of the incidence of these infections, how they have been treated and what the outcome was. The data is being analysed and evaluated with relevant interventions, such as, staff education and additional fluids being provided, to reduce the incidence of infections. The introduction of the analysis and evaluation of information about the identified infections addresses an area that was noted as requiring improvement during a previous audit. Surveillance reports are being provided and discussed at infection control committee meetings, staff team and registered nurse meetings and at the quality assurance meetings.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 20 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 55 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 | The human resources policy and procedures state staff will undergo a performance appraisal annually. Five of eight staff files that were reviewed do not have a current performance appraisal. | That performance appraisals are undertaken as per organisational policies to ensure service providers continue to safely meet the needs of the residents. | 180 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | No short term care plans are seen in seven of the seven residents’ files reviewed. All resident short term care plans are filed in a separate folder apart from the resident’s individual folder. On reviewing the short term care plan folder it is seen there are no written short term care plans for illnesses and injuries other than skin problems. | All identified short term problems relating to residents are documented in a short term care plan which includes identification of the problem, appropriate interventions and timely evaluation until the problem is resolved or transferred to a long term problem. The short term care plan is retained within the residents’ individual care plan file. | 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:**

A current open disclosure policy and procedure pertaining to the process is sighted. The quality manager informs that the registered nurse is usually the one who follows up with any changes in the health status of a resident with family members and that all staff contribute to keeping people informed. Two residents interviewed believe they are kept well informed and know what is happening for them. A review of incident forms shows that next of kin are being contacted about any incident and although a small section on the form relates to a brief of what was said, these are blank on the form. The quality manager and registered nurse explain that the content in the section above is discussed, as are any follow-up and/or ongoing issues. It is recommended that this conversation is briefly outlined in the relevant section of the form intended for the purpose.

Staff inform that they have not had any resident or day stay person for whom interpreter services have been required. A policy and procedure on interpreter services informs of options through the local District Health Board if required, as such services are otherwise limited in this district.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Written consent forms for a range of consent processes for advance directives, photographs, outings, release of information and influenza vaccination are in residents’ files and all forms sighted are signed and dated as required. This addresses an area that required improvement during the last certification audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A complaints policy and procedure that complies with Right 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is viewed within the organisation’s policy documentation. During two separate interviews, five of five caregivers and a registered nurse demonstrate their awareness of this document and of their responsibilities around reporting complaints. Staff inform that there is a communication record in residents’ files where minor verbal concerns are reported and that these are followed up by the registered nurse, and if necessary the quality and/or the general manager. Complaints are an agenda item for discussion at staff and registered nurse meetings as well as quality assurance meetings. The staff also describe where complaints/reportable events forms are available and inform that if a person requires a complaints form that they will also be provided with a pamphlet on the Code that has information about advocacy services.

A complaints register is being maintained and shows that one complaint has been logged for 2014, one in 213 and one in 2010. The register notes the date, name of the complainant, who or what the complaint was against, an acknowledgement date, the date the investigation was completed, what investigation into the written complaint occurred and what the outcome was. The register shows that complaints are being acknowledged the day after with the one in 2010 four days later. Copies of the full documentation associated with the different complaints, including the resulting correspondence are sighted in the complaints register.

##### **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:**

The O’Conor Memorial Home’s mission statement focuses on the provision of high quality care in a homely and safe environment, respect of the unique identity of each resident, a commitment to assisting residents to attain their optimum level of health and comfort, the provision of high standards of care and the encouragement of family/whanau.

A summary of the organisation’s philosophy, which reiterates parts of the mission statement also covers quality care, the empowerment of residents, providing an environment that promotes emotional, physical, social, intellectual and spiritual wellbeing, giving clear information, their rights and their friends and family, for example. The document describes ways in which the philosophy will be implemented such as through listening, providing opportunities, activities, information, tailoring care to individuals, promoting independence, autonomy and active participation supervision from a registered nurse and staff development.

A quality policy notes the goal of creating a continuous improvement cycle by way of implementing the quality plan and the business plan. This involves regular committee and team meetings and involving staff in the quality culture of the home. The quality management system is to guide these processes.

The O’Conor Institute Trust Board provides a governance structure for the O’Conor Memorial Home and has appointed a general manager to manager the operations of the home. The general manager has managed this facility for what will be six years in January and she reports to a committee of the Trust through manager’s reports and attendance at Trust committee meetings. A performance appraisal of the general manager is completed by the committee in December each year against a set of key performance indicators that are clearly outlined in the position description (sighted).

The general manager informs she has a Masters of Nursing, has worked at management level for the local district health board and in a large home care industry, as well as at a national level for an Accident Compensation Corporation project. She has a current annual practising certificate (sighted) and is maintaining her professional development with recent examples being attendance at health and safety training and ‘Walking in another’s shoes’ in 2014.

##### **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:** FA

**Evidence:**

A quality policy and a risk policy are sighted. These describe the strategies for their implementation with the quality policy referring to the wider quality management system. The risk policy includes a description of the risk management process which includes guidelines for assessing the level of risk, potential consequences, probability and effectiveness of the controls.

There are multiple layers at which the quality and risk management systems operate with monthly residents meetings, monthly team meetings with caregivers and wider staff groups attending, registered nurse meetings every six to eight weeks, infection control meetings three monthly, restraint committee meetings six monthly and quality assurance committee meetings approximately every four months. The general manager reports to the Trust Board committee approximately every three months with examples of the content being updates on incidents/adverse events, staffing, development, maintenance, staff training, financial actuals against the budget, restraints and the incidence of infections.

A range of organisational policies and procedures align with the Health and Disability Services Standards. The quality manager has responsibility for ensuring these are aligned with current good practice and service delivery and she informs that this is achieved by consulting and working with people with relevant expertise, such as the registered nurses for service delivery. The quality committee also participates in reviews of the documents. The document control system is described in the quality policy, includes the format and information required in headers and footers and the information to be in each folder. Documents are reviewed within a three year cycle and as necessary. Associated documents are referenced in each document, review dates are at the front page of the relevant folder and updates are occurring accordingly. Changes are recorded in a review and updates of documentation form, and once completed, new and revised policies are made available for staff to read and sign.

Minutes of the different meetings that contribute to implementation of the quality management system are sighted and there are a number of similarities on the agendas. For example most cover resident satisfaction (with a recent meal review having occurred at a residents’ meeting), results and reporting on internal audits, reportable events (including any written and/or verbal complaints), any performance management issues, health and safety, infection control and restraints. Health and safety is a dedicated topic in the policy documentation sighted and in the quality assurance meeting minutes. For example, there is evidence of analysis and evaluation of actions taken during and following the emergency situation that Cyclone Ita created earlier in 2014. Annual summaries of infection control data and an analysis of this is evident in the latest quality assurance meeting minutes. Trends are identified in incident/accident data for monthly and annual timeframes and evaluations of actions implemented as a result of these are occurring, Analysis and evaluation is occurring across a range of quality improvement data, information and processes, which addresses an area that was identified as requiring improvement for standard 1.2.3.6 at the last certification audit.

A comprehensive internal audit schedule is sighted, however the internal audits have got behind due to the Cyclone, the building upgrades and the extension to the facility. This was self-identified by the quality assurance team in July as a concern and a corrective action plan was put into place to address the shortcoming. Progress is being made with the plan and the scheduled internal audits are now only approximately two months behind but all are allocated and scheduled. However, urgent additional internal audits/reviews are being undertaken when indicated, as with a medication audit for ‘found medicine’.

There is a corrective action register, which holds documentation of numbered corrective actions that have been generated from a range of different sources. These are being progressively addressed and evaluated for the level at which they have been effective. Examples sighted include ones around employment contracts, overdue care plan evaluations and unsafe chemical storage. Continuous improvement actions are identified through the corrective action plan process, or other aspect of analysis of quality system information and/or data. These are mostly documented, or at least summarised, in the corrective action log.

A well-developed hazard register, last reviewed in May 2014, lists the identified hazards, their potential harm, whether significant or not, the proposed actions and the frequency of monitoring. These come under categories of general, care provision, food service provision, laundry/cleaning, clerical, outside and hazards specific to O’Conor Memorial Home. The hazard register includes hot water temperature, which addresses a previous required improvement.

Actual and potential risks are identified in a risk management plan under the categories of funding, human resources, information and communication, service information, facility and property management, care related and organisational management. Each includes associated risk factors, potential harm, risk levels, likelihood monitoring, control measures, responsibility and when completion might be due. Each risk is reviewed at least annually, although some of the controls are being reviewed more frequently as is evident with staffing levels and staff education for example.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Both the quality manager and the general manager are able to identify examples of statutory and/or regulatory obligations in relation to essential notification reporting to the correct authorities. Examples provided include occupational safety and health for a major event for staff, outbreaks of infection to the infection control nurse at the local district health board, any resident deaths to the GP, the police/coroner (when relevant) and the funders, and some time ago the manager was required to advise the Ministry of Health when there was no registered nurse cover for residents in hospital care over two separate shifts. Another example provided was informing Civil Defence when power was lost for six days and emergency management systems were put in place earlier this year following Cyclone Ita.

There is a bright yellow form used for reportable events. It is also used to record written complaints. The form is completed following any incident or adverse event and requires a description of what happened to be recorded. As per the incident/adverse event reporting policy these forms are then categorised into complaints, concerns and incidents, medication, property damage, resident falls, resident slips, skin tears, resident accidents/other, wandering, hazards and staff accidents. Registered nurses complete and follow up any incident involving medications, while the quality manager, general manager and registered nurses (depending on relevance) follow up on all others. The quality manager analyses and evaluates the data developed within and across the categories described. Recommendations are made and corrective actions are developed as required. Evaluation as to whether any recommended changes have worked is occurring for any interventions made as a result of the analysis and evaluation of the data. Reports are made at team meetings, registered nurse meetings and quality assurance meetings. Residents are informed of developments when they apply to them as an individual, such as for a person with frequent falls. At an organisational level examples of adverse events that have been followed through are when a number of skin tears were sustained on the previous radiators and when the analysis of medication errors were found to be related to medicines not being swallowed. Incident reporting is an agenda item for the quality assurance meetings.

##### **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:**

A list of professionals associated with the service shows that annual practising certificates are being checked for the two GPs who attend the residents and the pharmacists. A podiatrist used by the service comes under the District Health Board, as does a physiotherapist. Copies of current annual practising certificates of registered nurses are sighted in three personnel files of registered nurses that are reviewed.

Policies and procedures about the recruitment of staff (Employee Training and Development) are sighted. Staff undergo police checks and records of this process are in three of eight staff files checked, all of whom have been employed within the last year to eighteen months. Records of staff interviews are in four staff files, also for those staff more recently employed. All eight personnel files sighted have copies of job applications and/or curriculum vitae in their files and all have copies of signed individual or collective contracts on file. There is no evidence of employment of people unlikely to safely meet the needs of the residents.

According to policies and procedures, an annual performance appraisal process is in place to ensure there is an opportunity to address any staff concerns, performance and training. A performance appraisal is not sighted in the general manager’s file as this is held by a committee member, one other person has not yet been working at O’Conor for a year and one performance appraisal has just gone beyond a year. The remaining five are overdue since December 2011 or May 2013. Ensuring the performance appraisal process is maintained is an area requiring improvement.

A comprehensive staff orientation programme is in place, the contents of which include the organisation’s philosophy, a floor plan and orientation, rules and responsibilities, position description, rosters and payroll, health and safety policy and guidelines, fire protection, emergency management, home security, records and reporting, call bells, hoists and resident care areas for example. This is described in policy and procedure documents and checklists are completed during orientation that may take up to three months. A ’buddy system’ is in place whereby a person will do two morning, two afternoon and two night shifts alongside another staff person, although staff inform during interview that they are always well supported as they work in pairs. The quality manager informs that formal time with a buddy may be extended as required. A caregiver who has only been at the facility for a short time informs how during the orientation period, time is taken to go over sections of the programme with a senior staff person. All staff files viewed have evidence of the person undertaking an orientation programme. More recent records show the times, dates and names of those involved in the buddy system.

Positive feedback from staff is received about the multiple opportunities to upskill and attend different professional development options and/or training sessions. A range of core topics have been identified for all staff to attend one a year, such as infection control, fire and emergency response and medication competencies (for those who have their National Certificate in Aged Care) or once every two years such as restraint and consumer rights. Caregivers are supported to complete their National Certificate in Aged Care and the quality manager informs they are currently in transition as to the provider of this. All caregivers working in dementia have undertaken the required four levels of training and most have also completed the programme of ‘Walking in another’s shoes’. One person who has recently commenced in the facility is in the process of commencing the dementia based training. Senior staff, such as registered nurses, the managers and team leaders, are expected to maintain their first aid certificate. Copies of these certificates are in personnel files.

Records of completed training are filed by the quality manager in numerous ways, including by subject matter, individually in personnel files, according to evaluations and according to self-recording system. There are gaps in some and yet these records are completed in others. There is no evidence to suggest there are significant gaps in the identification, planning and facilitating of the education and training of staff with multiple opportunities provided and evidence of staff being followed up with a quiz, or being asked to attend a next session if they have not completed a requirement. However, the system is difficult to follow and it is recommended this is revised and simplified to enable other people easier access to these records.

##### **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:**

According to policies and procedures, an annual performance appraisal process is in place to ensure there is an opportunity to address any staff concerns, performance and training. A performance appraisal is not sighted in the general manager’s file as this is held by a committee member, one other person has not yet been working at O’Conor for a year and one performance appraisal has just gone beyond a year. The remaining five are overdue since December 2011 or May 2013. Ensuring the performance appraisal process is maintained is an area requiring improvement.

**Finding:**

The human resources policy and procedures state staff will undergo a performance appraisal annually. Five of eight staff files that were reviewed do not have a current performance appraisal.

**Corrective Action:**

That performance appraisals are undertaken as per organisational policies to ensure service providers continue to safely meet the needs of the residents.

**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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A policy titled staff numbers and skill mix is sighted and includes a list of factors taken into consideration when allocating staff numbers. Examples of these include organisational goals and objectives, acuity of service delivery, any significant infections, the skill levels of staff, age of staff, gender mix of staff, if there is any opportunity for families/whanau to provide input, Maori cultural values, the availability of equipment and the speed at which staff are able to attend to residents.

The general manager authorises staff numbers and she informs of the factors she takes into account, which are mostly consistent with the policy. She notes that she refers to the Ministry of Health guidelines to help benchmark, ensures a registered nurse is on duty 24 hours a day with two on Monday and Friday when the workloads are higher, listens to feedback at team and registered nurse meetings, reviews the time and place any additional or unexpected incidents occur and ensures new staff are not being orientated with inexperienced staff. This latter comment was a factor staff had already informed during interview that new staff only work alongside experienced staff. The general manager states that sickness is covered by staff employed on a casual basis and some by part time staff and showed examples of this in the roster.

Three weeks of rostered duties are sighted and staffing levels over these weeks are as follows:

The dementia service has two caregivers working morning shifts 7 am to 3 pm and one 8 am to 12.30 pm. A caregiver comes across from the main part of the home for one hour 7 am to 8 am.

Afternoon shifts are covered by a person covering 2.45 pm to 11.15 pm and another from 4.30 pm to 8.30 pm.

The rest home and hospital area is covered by four full shifts from 7 am to 3 pm, one person 7 am to 1.00 pm and another 7 am until 10 am. Afternoon shifts are covered by one person 2.45 pm to 11.15 pm, one between 4.30 pm until 8 pm, a 3.30 pm until 11.15 pm person and another 4 pm to 8.30 pm.

Two caregivers and a registered nurse cover the night shift for the entire facility.

A diversional therapist work 9 am to 4.30 pm Monday to Friday.

Caregivers and registered nurses are asked during interviews about their opinions on staffing levels. All suggest that although it can be busy at times, especially in the evenings, they believe staffing levels are fair and reasonable.

##### **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:**

Seven of seven resident files are reviewed. All seven files display a consistent approach to documenting the full name and designation of the person entering the information and the date of the documentation. On speaking with both the quality coordinator and the registered nurse a commitment is verbalised to include this information and this is evidenced by the change in forms from the previous certification audit. The previous area requiring improvement has been met.

##### **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:**

Residents are admitted to the O’Conor Memorial Home following a needs assessment completed by a designated Needs Assessment and Service Coordination Agency which determines the appropriate level of care. The client and/or relative completes an O’Conor Memorial Home Interview and Assessment form and signs an Admission Agreement. The Admission Agreement is sighted and discussed with the nurse manager and quality coordinator. It now contains all details documented in section D13 of the Aged Residential Care contract thus meeting the required area for improvement from the previous audit. The policy of the home is to assess new residents on the day of admission and this is reflected in the residents’ files viewed. The needs assessments forms are also sighted.

##### **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:**

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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 1.3.3: 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:**

A qualified registered nurse carries overall responsibility for the care of the residents. The facility is staffed 24 hours a day by a registered nurse with two registered nurses on site most days as well as the nurse manager Monday to Friday.

Medications are dispensed by a registered nurse or carer who has been trained and assessed as competent to dispense prescribed medications. It is a requirement of the facility for this competency to be reassessed yearly. All staff are encouraged to complete on-going education both formal and in-house. The planned in-house education is being maintained as detailed in Standard 1.2.7. New care staff are buddied and monitored by the registered nurse until assessed as competent to work independently.

A qualified diversional therapist provides an activities programme which encompasses individual, group and community activities. There is availability of a qualified physiotherapist, infection control specialist and dietitian and practising certificates are sighted for the general practitioners and pharmacist involved with the facility. A podiatrist visits the facility. There is a quality coordinator employed and a registered nurse acts as the infection control coordinator.

Prior to entry each resident completes an O’Conor Memorial Home interview and assessment form and receives an assessment from the needs assessment team confirming the level of care required. An initial care plan is developed with the resident and/or family on the day of admission and signed by both the registered nurse and resident/relative. Long term care plans are written within three weeks of entry to the facility to guide on-going care. The long term care plan is developed in consultation with the resident and/or their family following a comprehensive assessment procedure. Each section of the care plan is signed and dated by the registered nurse and either the resident or their next of kin. These care plans reflect the resident’s goals and appropriate interventions which are observed to be delivered in a timely manner (eg, medications given as prescribed and staff responding promptly to residents’ requests for assistance). The long term care plan is evaluated and rewritten at least six monthly. Seven residents’ folders were reviewed, the registered nurse spoken with and three residents. All confirm assessments are completed in a timely manner with the involvement of the resident and/or their family. This addresses a quality improvement required from the previous audit.

Residents are well presented with clean, tidy clothing. Three of three residents spoken with expressed their satisfaction with their care. Meals are delivered three times a day interspersed with morning and afternoon tea and supper. The general practitioner states the facility and in particular the new dementia unit is ‘going very well’ and he is happy with the mix of staff. He also states his confidence in the senior registered nurses. This general practitioner provides medical cover for three aged care facilities and states his commitment to quality care. He is supported in his care of the residents by a geriatrician and psycho-geriatrician. At present this general practitioner visits the facility fortnightly and as required, however from the 1 October 2014 he will be visiting weekly and as required.

Staff are observed to interact in a cooperative and consultative manner which supports quality team-based care for the resident. The roster indicates staff work in teams. Various staff are observed discussing resident care (eg, carers with registered nurses, kitchen staff with carers and the diversional therapist with the registered nurse and carers). A formal handover takes place between shifts.

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

Tracer two – rest home – *XXXXXX This information has been deleted as it is specific to the health care of a resident.*

Tracer three – dementia care- *XXXXXX This information has been deleted as it is specific to the health care of a resident.*

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Seven of seven resident files are viewed and discussed with the registered nurse. The long term care plan includes sections on communication, memory, behaviour, skin care, mobility, oral hygiene, nail care, elimination, nutrition, sleep, safety, spirituality, sexuality and intimacy, and medical condition. Each individual section contains the name and designation of the person completing the care plan and the date of completion. There is also a resident or family member signature on each section confirming involvement and approval of the section of the care plan. For one care plan, the registered nurse explains the different dates attached to the signatures of the person formulating the care plan, and the family member, as the care plan required faxing to the family member for reading and approval. This action, and the responses of three of the three residents spoken with, confirms the involvement of the residents and/or their families in developing the care plan.

The registered nurse states supplementary assessments are carried out to inform the long term care plan. The supplementary assessments include continence, falls risk, mini mental, sleep, oral, and pain assessments, a nutrition profile and the Norton pressure sore risk assessment. The dates of completion of these assessments in the seven folders reviewed are seen as corresponding closely with dates of the completed long term care thus meeting the requested improvement from the previous audit.

##### **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 1.3.6: 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:**

Seven of seven residents’ files and care plans are seen and confirm residents receive adequate and appropriate services which meet their assessed needs and goals. The residents’ folder includes an initial assessment carried out on the day of admission. This assessment forms a care plan to cover the interim period before a long-term care plan is developed within three weeks. There are sections in the care plan relating to communication, memory, behaviour/mood, mobility, oral hygiene, nail care, skin, elimination, nutrition, sleep, safety, spirituality and cultural, and sexuality and intimacy. The assessments document problems and goals. Written interventions are read and considered appropriate to the problem and/or goal. Each care plan section is signed by either the resident of their next of kin indicating approval of the written interventions.

On viewing meal delivery all residents received meals matching their nutritional profile.

Residents have access to continence products related to their assessed need, social spaces, televisions and telephones, a chapel and clean and fresh linen supplies. Staff are observed to speak with residents in a friendly and pleasant manner. The general practitioner states his satisfaction with the service provided by the facility.

The three residents reviewed have examples of where interventions are developed to meet their unique needs.

##### **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 a qualified diversional therapist working over the three areas of the facility Monday to Friday. She covers the activities programme for the hospital, rest home and the dementia care unit. The diversional therapist has completed training in diversional therapy as well as ACE modules in aged care and dementia care. The diversional therapist is assisted one day per week by the dementia care unit team leader who also holds a qualification in diversional therapy. This day is spent entirely within the dementia unit. A full evening and weekend activities programme for the dementia care residents is delegated to the caregivers.

The activities plan is currently being re-evaluated and redeveloped. This process began two-three months ago. The plan for the current fortnight is reviewed. There is a variety of physical, intellectual and religious activities as well as outings. Plans are maintained for each activity. These plans include the group size, required resources, the benefits of the activity, health and safety considerations, and any adaptations required for individuals and evaluations of the activity.

Opportunities exist for individual, group and community activities. Each Thursday the residents are able to go shopping in the O’Conor Home van. On this trip the diversional therapist ensures she is accompanied by at least one able-bodied person. There is a chapel on site which is used for religious gatherings and staff weddings. Various religious denominations visit the facility - Anglican, Roman Catholic, Salvation Army and Latter Day Saints. The Anglican Church and the Salvation Army are also involved in community activities.

The diversional therapist documents in each resident’s care plan. Documentation includes a personal profile which is completed on admission, a monthly record of involvement set out on an annual plan and progress notes are written at least weekly. The activities plan for one dementia care resident includes a weekly planner of daily morning and afternoon activities.

Three residents were spoken with. All state their satisfaction with the variety and availability of activities, including the community involvement.

##### **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:** PA Low

**Evidence:**

Seven of seven residents’ files are reviewed and a discussion held with the registered nurse regarding the evaluation process. Supplementary assessments for the five residents who have lived in the facility longer than six months are dated as evaluated six monthly and correspond closely to the date of their long-term care plans. Prior care plans for these residents are viewed and confirm a six month evaluation has taken place. The two other residents have not lived in the facility long enough to receive a six month evaluation.

The registered nurse demonstrates a calendar with documented review dates which displays forward planning of six monthly reviews for each resident. Previous reviews of care plans are filed in a separate resident folder. A visual overview of these care plans confirm regular six monthly evaluations prior to rewriting the new current care plan.

Three of three residents spoken with confirm they are involved in re-evaluating and planning their care plan each six months.

The daily progress notes of all seven files record at least daily comment on the resident’s progress toward meeting their goals..

The planned active evaluations of the care plans and daily progress notes confirm this required area for improvement has been met.

There is a folder which contains short term care plans separate from the residents’ individual files. All short term care plans in the folder relate to skin problems. On speaking with the registered nurse she explains the process for other identified short term problems is to document these in the daily progress notes along with action taken and progress towards resolving the problem. The quality coordinator also talks of infections being recorded in the infection surveillance statistics but not documented in a specific short term care plan. Therefore there is no planned process specifically for documenting short term problems with appropriate interventions and timely evaluation other than for skin problems. This is an area requiring improvement.

One hospital resident has a short term problem identified in his long term care plan which the registered nurse believes may become a long term problem. This problem is not written as a specific short term problem with interventions and evaluation to decide whether it will become long term.

One rest home resident has two problems written in her long term care plan which display appropriate interventions once dealt with however neither of these problems were written into a short term care plan at the time they were active.

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##### **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:** PA Low

**Evidence:**

There is a folder for short term care plans with a format that includes problem identification, interventions and evaluation. This short term care plan folder is seen to include only problems relating to skin (ie, skin tears). There are no short term care plans for other identified problems, such as urinary tract infections, injuries or short term illnesses which require separate care planning from the long-term care plan. No short term care plans are seen filed within the seven residents’ care plan folders viewed. On discussing the identification and documentation of residents’ short term problems, interventions and evaluation, other than those relating to skin, with the registered nurse and quality coordinator they state these problems are documented in the daily progress notes.

**Finding:**

No short term care plans are seen in seven of the seven residents’ files reviewed. All resident short term care plans are filed in a separate folder apart from the resident’s individual folder. On reviewing the short term care plan folder it is seen there are no written short term care plans for illnesses and injuries other than skin problems.

**Corrective Action:**

All identified short term problems relating to residents are documented in a short term care plan which includes identification of the problem, appropriate interventions and timely evaluation until the problem is resolved or transferred to a long term problem. The short term care plan is retained within the residents’ individual care plan file.

**Timeframe (days):** 180 *(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:** FA

**Evidence:**

The medication management system is discussed with the registered nurse. Prescribed medications are collected by the registered nurse directly from the pharmacist and transferred to the facility where they are checked in by the registered nurse and one other person who has a current medication competency qualification. A notebook of recorded dates of receipt of medication is viewed with the corresponding signatures of the two people checking in the medication.

The majority of tablets are blister packed with eye drops and individual liquid medication clearly labelled and dated. A system exists for changing eye drops on the first of each month to minimise the risk of using out of date eye drops. No resident is prescribed insulin at present. Medications are kept in a clean locked cupboard in a room which is accessed by key pad lock. There is a system for rotation of stock, such as inhalers. Controlled drugs are stored in a key pad locked metal safe firmly secured to a shelf within the locked cupboard. The controlled drug record book is viewed which displays complete recordings and weekly drug stock checks.

Two medications have been approved for crushing by either the pharmacist or general practitioner. This approval addresses an area for improvement identified at the previous audit.

A medication round is observed. The medications are transported to the dining room via a trolley which houses the blister pack folders in locked drawers. The registered nurse administers each medication addressing the resident by name and waiting to ensure the medication is taken. The tablets are delivered in a ‘no touch’ manner and each resident is offered a glass of water to swallow their tablets. Medications are administered by either a registered nurse or staff who have completed an annual competency assessment. Records of confirmation of competency and annual practising certificates for registered nurses are viewed.

The inside front of the medication folder contains a record of sample signatures for all staff who dispense medication. Ten medication records are reviewed. There is an identification photograph measuring approximately 10 centimetres square attached to the front page of each resident’s medication record along with clearly noted name, date of birth, NHI number and identified allergies. Medications are prescribed according to legislative requirements and a record of three monthly review of medications is seen.

A process for self-administration is written into the medication policy and includes assessment, checking, recording and storing. The registered nurse states there are only two residents self - administering at present and they are only administering their inhalers. These residents record each time they administer their inhalers. A completed assessment form is viewed.

##### **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:** FA

**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 1.3.12.3 (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 menu offered to the residents rotates six monthly between summer and winter and is developed with guidance from a qualified dietitian every two years. The menu is displayed daily on a whiteboard in the dining room. Residents are offered the opportunity to comment on the menu at the resident meetings and via a satisfaction survey. There is evidence of their comments and requests being taken into consideration, such as the cook reporting a general dislike of mushrooms.

The cook explains the kitchen layout includes separate areas for receiving and storing goods, meal preparation, serving and dishwashing and this is confirmed on viewing. Goods are delivered via a door to the exterior while the serving area is attached to the dining room. On a tour of the kitchen with the cook it is seen that temperature records of food and storage facilities, such as freezers and fridges are documented. Cleaning schedules are fixed to the kitchen wall with signing records displaying completion of duties (eg, daily cleaning of the sterilizer). A recycling system separates compostable from disposable waste.

Stock, including frozen and refrigerated, is labelled, dated and stored in a rotating system. Food in the freezer is seen to be separated into categories such as meat, fish, desserts and vegetables. Chilled foods are delivered directly into the chilled and dry goods are stored off the floor. Spare containers are kept for restocking dry goods while emptied containers are washed, dried and kept for restocking.

A fire extinguisher, fire hose and fire blanket are sighted in the kitchen. Cleaning chemicals are stored in a locked cupboard. A container of disposable hats is at the entrance to the kitchen area.

The cook states the whiteboard above the serving are, which lists specific dietary needs, dislikes and crockery/utensils requirement, is referred to while serving the meals. A folder of individual nutritional profiles is kept in the kitchen and individualised dietary profiles are seen in each residents care file. These dietary profiles are signed and dated by the registered nurse. The cook reports alternative food is provided for residents with food allergies and attempts are made to offer alternatives for those with dislikes.

There are two cooks and both are certificated in safe food handling. Records confirm one completed a safe food handling course in 2012 and the other 2013. A certificate is displayed on the kitchen wall confirming the kitchen assistant has completed a nine hour course on safe food handling.

The cook explains the midday main meal is cooked by 11.15 am and then placed in the steamer to maintain warmth. Records are kept of the steamer temperatures. The food is observed to be transported to the two outlying dining areas on labelled trays in a scan box which is plugged in at 11.30 am to ensure it maintains the heat in the food. The third dining room is attached to the kitchen and food is served directly onto plates from the kitchen serving area and transported to the resident by care staff. Two care staff are seen assisting the residents in this dining room. The registered nurse is also present dispensing medications. The registered nurse states the rest home and hospital residents are able to choose which of the two dining rooms they wish to eat their meals. The residents in the dementia unit have a dining room within their secure environment.

Three residents are spoken with (two rest home and one hospital.) The hospital resident stated the food was good and soft which is what she needs. The two rest home residents stated the food was ‘good’ and ‘alright’.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

#### Standard 1.4.2: 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:**

A range of issues identified as requiring improvement at the last certification audit about maintenance and plant have been addressed. A maintenance programme is now in place and the quality manager informs that a long term maintenance review and replacement programme is also under development with an architect. The relief maintenance person explains to the auditor how the repair work and maintenance tasks are now being signed off and dated once completed. The records are sighted. New wall mounted water heaters are in place and have automatic (digital electronic controls) cut-offs when the temperatures rise above a certain level. Monthly monitoring and spot checks of water heaters is also occurring and evidence is sighted. The boiler is coal fired and heats all water for the facility, although some areas also have electrical back-up. The van has had a recent service and warrant of fitness and the mechanic has specified the hoist has been checked. Annual testing and tagging of electrical equipment is occurring on the day of audit and the technicians explain their process to ensure all new equipment is tracked down. There is no evidence of outstanding maintenance, which addresses an area identified as requiring improvement at the last certification audit.

A Code of Compliance dated 20 August 2014 is on display and is sighted. It was issued by the Buller District Council, following an upgrade of the existing buildings (earthquake proofing) and the building of a 20 bed extension to the existing building. This addresses a required improvement from the partial provisional audit (under 1.4.2.1), as well as meets a requirement of this surveillance audit. The next building Warrant of Fitness is due in June 2015.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### 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:** FA

**Evidence:**

A copy of the letter of notification from the New Zealand Fire Service of approval of the fire evacuation plan is sighted, dated 14 March 2014 is sighted. This confirms that the requirement from the partial provisional audit was addressed.

##### **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.)*

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

There is no longer a smoking room in this facility. The old smoking room has been converted into a conservatory area. People who wish to smoke are asked to do so in a designated area outside where there is seating and a canopy covering. The elimination of the internal smoking room has addressed the area that required improvement that was identified at the last certification audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

# 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:**

Policy and procedure documents for restraint minimisation and safe practice are sighted and include a statement at the front that states restraints and seclusion are not used at the O’Conor Home.

A definition for enablers states they are voluntary and there is a list of factors to be taken into account before an enabler may be used. These include the physical and psychological health of the person, any identifiable risks, the care plan, any alternative options have been considered, the legal status/implications of what is planned and the previous experience of the person.

A register of enablers is sighted and notes the date, name of the person, a review date, the type of enabler, the signature and designation of the staff person. Enablers are reviewed as part of the six monthly care plan review and their use is fully reassessed at this time. The care plans of two people using enablers confirm the reassessment process and one other person has only recently been admitted. The consent from next of kin has been obtained due to a physical disability preventing the person doing it themselves.

Staff are clear during interview of the difference between a restraint and an enabler and are able to inform that bed rails, a fall-out chair and a lap belt are the three types of enablers currently in use in this facility.

Enabler use is discussed at the six monthly restraint team meetings and reports are further discussed and reviewed at the quality assurance meetings, for which it is an agenda item. The general manager informs she reports their use in her management reports to the O’Conor Trust Board committee.

##### **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.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control policies and procedures describe the infection prevention and control surveillance processes. Infections that have been identified for inclusion in the surveillance process are eye, ear and nose; upper and lower respiratory tract; skin and soft tissue; diarrhoeal disease; and those identified as multi-resistant.

Any staff member may report signs and symptoms of an infection and caregivers inform during interview that they report these to a registered nurse, who will tell them if they need to do anything else. A registered nurse ticks the boxes on an infection reporting form with a range of details, including for samples taken and treatment provided.

The registered nurse and quality manager enter the data into a register and summarise the data according to the infection type. An analysis and evaluation process is being implemented on a monthly and annual basis and for individuals if this is relevant, such as for a person with recurrent urinary tract infections.

The register and the analysis of infection control data are taken to the infection control meeting, the registered nurse meeting, the quality assurance meeting and are in the manager’s report to the committee. The quality manager notes that corrective actions, such as increasing the availability of fluids, the introduction of prophylactic antibiotics and education on the prevention of noro-virus are three examples provided of actions taken as a result of infection control reports. The analysis and evaluation of the incidence of the identified infections that is occurring has addressed an area identified as requiring improvement at the last audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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