Lakewood Rest Home Limited

Current Status: 7 October 2014

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

General overview

Lakewood provides a specialised dementia care service for up to 36 residents. On the day of audit there were 26 residents residing at the facility. The day to day running of the service is managed by an experienced diversional therapist with management qualifications. The owner/director is a registered nurse and provides clinical management and oversight of the service. Lakewood rest home continues to provide care that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. Staff interviewed and documentation reviewed identified that the service has a quality system implemented to meet the needs of residents. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. The care service promotes the residents' individuality and independence.

There are improvements required around informed consent, admission agreements, policy review, incident and infection data being feedback to staff, writing of resident's progress notes, aspects of care planning and medication, dating of decanted food and calibration of equipment.

Audit Summary as at 7 October 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

Indicator	Description	Definition
	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 7 October 2014

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

Organisational Management as at 7 October 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 7 October 2014

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

Safe and Appropriate Environment as at 7 October 2014

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

Restraint Minimisation and Safe Practice as at 7 October 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 7 October 2014

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

Audit Results as at 7 October 2014

Consumer Rights

Lakewood Rest Home provides care in a way that focuses on the individual resident. There is a Maori Health Plan and ethnicity awareness policy/procedure supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. A two yearly staff training programme supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are in place and documented. Residents and family interviewed reported satisfaction with the service being provided. There are improvements required around informed consents and admission agreements.

Organisational Management

Lakewood Rest Home is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly staff meetings. An annual resident satisfaction survey is completed and there are regular resident/family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and

support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around reviewing of policies, dissemination of quality data and progress notes writing.

Continuum of Service Delivery

There are entry and admission procedures in place. Residents are assessed prior to entry to the service. Family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with family/whanau involvement included where appropriate. Improvements are required in relation to timeframes for completion of risk assessments and reviews and completion of all assessment requirements. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. A range of activities are available at Lakewood rest home based on resident's interests and abilities. Improvements are required in relation to completion of all activities care planning documentation.

The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration receive training and caregivers complete an annual competency assessment. Improvements are required whereby the registered nurse completes medication competency. Resident medications are reviewed by the residents' general practitioner at least three monthly. Improvements are required in relation to medication administration documentation and practice.

Lakewood rest home has food policies and procedures for food services and menu planning appropriate for this type of service. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Staff have completed safe food handling training and qualifications. Improvements are required in relation to dating of decanted foods.

Safe and Appropriate Environment

Lakewood rest home has a current building certificate that expires on 1 June 2015. Maintenance is carried out. Improvements are required where by medical equipment is checked and calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a large communal lounge and dining area, a smaller dining and lounge area and a quiet lounge. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry which includes storage of cleaning and

laundry chemicals. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. Hot water temperatures are monitored and recorded. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Restraint Minimisation and Safe Practice

The service has policies and procedures which align with the required standards. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were two residents assessed as requiring restraint and no enablers. Staff are required to attend restraint minimisation and safe practice education. Restraint consent, assessments and care plans are maintained for residents with restraint and staff complete restraint competencies. Restraint review and approval includes family input.

Infection Prevention and Control

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

HealthCERT Aged Residential Care Audit Report (version 4.2)

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:	Lakewood Rest Home Limited
Certificate name:	Lakewood Rest Home Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit			
Premises audited:	Lakewood Rest Home			
Services audited:	Dementia care			
Dates of audit:	**Start date:**	7 October 2014	**End date:**	8 October 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:	35

Audit Team

Lead Auditor	Susan Bowness	**Hours on site**	12	**Hours off site**	6
Other Auditors	Rosie Dwyer	**Total hours on site**	12	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	Lisa Cochrane			**Hours**	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37

Number of residents interviewed		Number of staff interviewed	14	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	25	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 3 November 2014

Executive Summary of Audit

General Overview

Lakewood provides a specialised dementia care service for up to 36 residents. On the day of audit there were 26 residents residing at the facility. The day to day running of the service is managed by an experienced diversional therapist with management qualifications. The owner/director is a registered nurse and provides clinical management and oversight of the service. Lakewood rest home continues to provide care that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. Staff interviewed and documentation reviewed identified that the service has a quality system implemented to meet the needs of residents. An orientation programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. The care service promotes the residents' individuality and independence.

There are improvements required around informed consent, admission agreements, policy review, incident and infection data being feedback to staff, writing of resident's progress notes, aspects of care planning and medication, dating of decanted food and calibration of equipment.

Outcome 1.1: Consumer Rights

Lakewood Rest Home provides care in a way that focuses on the individual resident. There is a Maori Health Plan and ethnicity awareness policy/procedure supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. A two yearly staff training programme supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are in place and documented. Residents and family interviewed reported satisfaction with the service being provided. There are improvements required around informed consents and admission agreements.

Outcome 1.2: Organisational Management

Lakewood Rest Home is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly staff meetings. An annual resident satisfaction survey is completed and there are regular resident/family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are improvements required around reviewing of policies, dissemination of quality data and progress notes writing.

Outcome 1.3: Continuum of Service Delivery

There are entry and admission procedures in place. Residents are assessed prior to entry to the service. Family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with family/whanau involvement included where appropriate. Improvements are required in relation to timeframes for completion of risk assessments and reviews and completion of all assessment requirements. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. A range of activities are available at Lakewood rest home based on resident’s interests and abilities. Improvements are required in relation to completion of all activities care planning documentation.

The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration receive training and caregivers complete an annual competency assessment. Improvements are required whereby the registered nurse completes medication competency. Resident medications are reviewed by the residents’ general practitioner at least three monthly. Improvements are required in relation to medication administration documentation and practice.

Lakewood rest home has food policies and procedures for food services and menu planning appropriate for this type of service. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Staff have completed safe food handling training and qualifications. Improvements are required in relation to dating of decanted foods.

Outcome 1.4: Safe and Appropriate Environment

Lakewood rest home has a current building certificate that expires on 1 June 2015. Maintenance is carried out. Improvements are required where by medical equipment is checked and calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a large communal lounge and dining area, a smaller dining and lounge area and a quiet lounge. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry which includes storage of cleaning and laundry chemicals. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. Hot water temperatures are monitored and recorded. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Outcome 2: Restraint Minimisation and Safe Practice

The service has policies and procedures which align with the required standards. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were two residents assessed as requiring restraint and no enablers. Staff are required to attend restraint minimisation and safe practice education. Restraint consent, assessments and care plans are maintained for residents with restraint and staff complete restraint competencies. Restraint review and approval includes family input.

The service has policies and procedures which align with the required standards. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were two residents assessed as requiring restraint and no enablers. Staff are required to attend restraint minimisation and safe practice education. Restraint consent, assessments and care plans are maintained for residents with restraint and staff complete restraint competencies. Restraint review and approval includes family input.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (owner/director) is responsible for coordinating education and training for staff.

The infection control coordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	42	0	7	1	0	0
Criteria	0	91	0	9	1	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written	PA Low	a) Three of six residents (two permanent residents and one	a) Obtain written documentation for all	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		consent is obtained where required.		respite) did not have signed informed consent forms completed; b) two of six residents (one respite and one permanent resident) do not have a signed admission agreement.	residents in relation to informed consent to guide staff; b) ensure all residents have a signed admission agreement in place as per the ARC contract.	
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.3	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.	PA Low	There is no documented evidence that all policies have been reviewed at regular intervals as evidence in nursing sections 1-16 and 17-34	Ensure that all policies are reviewed at regular intervals/annually.	90
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is no documented evidence that resident data regarding incidents/accidents and infections have been discussed/reported to staff.	Ensure that all quality data is available and fed back to staff.	90
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		their assessed needs and desired outcome/goals.				
HDS(C)S.2008	Criterion 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.	PA Low	a) One resident did not have an initial assessment and long term care plan developed within the expected time frames. The resident was transferred from another facility and the previous assessments and care plan were utilised for four months before new assessments and care plans were developed; b) four of five permanent residents have not had risk assessment reviews completed within the expected timeframes; c) Five of six resident files sampled evidence that there are gaps in the progress notes of up to 10 days	a) and b): ensure all assessments, care plans and reviews are conducted within the expected time frames as per the ARC contract; c) Ensure that all residents' progress notes are written more frequently	90
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 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	PA Low	a) Wound assessments are incomplete or not done at all for three of six residents with wounds; b) challenging behaviour assessment has not been completed for a resident	a) Ensure all residents with wounds have a wound assessment completed; b) ensure those residents who display challenging behaviours are appropriately	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		planning.		displaying documented aggressive behaviours; c) one respite resident has an incomplete initial assessment. A comprehensive short term care plan is in place for this resident.	assessed; c) ensure all respite residents have initial admission assessments completed.	
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	On review of permanent resident files (five of six), it is noted that neither the long term care plan nor the activities plan includes specific activities or diversional therapies which best manages the resident's behaviour over a 24 hour period (as per the ARC contract).	Ensure that each resident's care plan includes behaviour management strategies (including diversional therapies) which cover a 24 hour period.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Moderate	a) Caregivers have been administering an evening dose of insulin without a current medication order. The	a) ensure that correct procedures are followed when administering medications; b) medication	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		resident had a new medication chart written up by the GP on 14 August 2014. The resident had previously been given two daily doses of insulin as per the GP instructions, however, when the new chart was written up, the evening dose of insulin had inadvertently been left off the medication chart. Care staff had continued to administer the evening dose without an order. The medication chart was rectified by the GP on the day of audit to reflect the correct order; b) on review of one resident medication order and administration signing sheet, it was noted that one dose of a B12 injection was given outside the prescribed time frame (at a five month interval instead of three monthly); c) weekly checks of controlled drugs has not occurred; d) the key to the controlled drug safe was observed to be left in the lock – this was removed on the day of audit and placed on the medication competent staff member's key ring. A system of signing over the keys at shift change was instigated on the first day of audit; e) the	must be administered according to general practitioners instructions; c) conduct weekly checks of the controlled drugs and record in the controlled drug register; d) ensure that the safety and security of controlled drugs are maintained at all times; e) provide evidence that the medication fridge is monitored for safe temperatures.	

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				medication fridge has not had temperature monitoring conducted.		
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	The registered nurse has not completed an annual medication competency.	Ensure that all staff who administer medications have annual medication competencies completed.	90
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	On a tour of the kitchen, it is noted that decanted dry goods in the pantry are not dated with best before or expiry dates.	Ensure all decanted dry goods are stored appropriately, labelled and dated with an expiry date or best before dates.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Medical equipment and scales have not been calibrated by an authorised technician.	Ensure that all medical equipment is calibrated and checked by an authorised technician.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Lakewood Rest Home has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the in-service programme. Interview with two caregivers demonstrate an understanding of the Code. Elder abuse training is included in the two-yearly in-service programme. Relatives (five) confirm staff respect privacy, and support residents in making choice where able.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The resident/family meetings (minutes sighted) also provide the opportunity for residents/family to raise issues. Relatives interviewed (five) inform information has been provided around the Code. The management team informs an open door policy for concerns or complaints.
D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, advocacy and Health & Disability Commission. The owner/director and registered nurse describe discussing the information pack with residents/relatives on admission.
D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect, which is included in the training programme. A resident satisfaction survey is completed annually (September 2014). Survey forms were still being returned at the time of audit. The owner/director contacts families directly if there are any concerns noted on the survey. Interview with five family members informed satisfaction with the service being provided.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with two caregivers describe how choice is incorporated into resident cares. There is an abuse and neglect policy being implemented and staff attend education around abuse and neglect (August 2014 with 16 staff attending).
D4.1a Six resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs.
D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Maori tikanga best practice guideline information is clearly visible in the hospital/rest home and dementia unit. Staff receive cultural training. Training occurred in September 2012. Cultural needs and support is identified in care plans. There is an established Maori health plan and individual care plans include the cultural needs of residents. Currently there is one resident in the service who identifies as Maori.

A3.2: There is a Maori health plan, which includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).

D20.1i: The service has developed a link with local Maori services such as George Heauka (Ngai Tahu). There are also staff at the service acting as links for local Maori.

The policies for Māori identify the importance of family/whānau. Interviews with two caregiver's one registered nurse and one manager the importance of family involvement. Discussion with five family members, confirm that they are regularly involved.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with one owner/director and one registered nurse confirm an awareness of professional boundaries. Interview with two caregivers could discuss professional boundaries in respect of gifts.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

Lakewood Rest Home has a suite of appropriate policies and procedures that are updated as necessary (# link 1.2.3.3). There is an active culture of on-going staff development with the ACE programme being implemented. There is evidence of education being supported outside of the prescribed training plan such as wound care.

A2.2 Services are provided at Lakewood Rest Home that adhere to the health & disability services standards.
D1.3 all approved service standards are adhered to.
D17.7c There are implemented competencies for caregivers and registered nurses including: medication and manual handling. RNs have access to external training.

Relatives interviewed (five) were positive about the care they receive. Interview with two caregivers inform they are supported by the RN's and management team.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. All ten incident forms reviewed across September (2014) identify family were notified following a resident incident. Interview with two caregivers, and one owner/director and one registered nurse inform that family are appropriately notified following a resident change in health status. The service circulates a regular news letter to relatives as sighted for spring 2014.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b relatives (five), interviewed stated that they are informed when their family member's health status changes or of any other issues arising.
D11.3 The information pack is available in large print and this can be read to residents.

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: PA Low

Evidence:

Lakewood rest home has policies and procedures relating to informed consent and advanced directives. A review of six files (five permanent and one respite) identified that informed consent documentation is available for photos, health information and outings. Improvements are required whereby all residents have a signed informed consent. Advanced directives are reviewed by the RN, NOK and GP and if no living will is in place, then all residents are for resuscitation. Advised that informed consent and advanced directives are discussed as part of the admission process.
There were four admission agreements sighted which were signed by the nominated representative. One respite resident and one permanent resident do not have a signed admission agreement in place. Improvements are required in this area.
Discussion with five family identified that the service actively involves them in decisions that affect their relatives' lives.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

A review of six files (five permanent and one respite) identified that three of six files included informed consent collected for photos, health information and outings as part of the admission process and agreement and these were signed by the resident's representative. Signed admission agreements are completed in four of six permanent resident files reviewed. Advised that the service has attempted to gain signed admission agreements from families and representatives via email and letter contact, however, not all families have provided the service with this.

Finding:

a) Three of six residents (two permanent residents and one respite) did not have signed informed consent forms completed; b) two of six residents (one respite and one permanent resident) do not have a signed admission agreement.

Corrective Action:

a) Obtain written documentation for all residents in relation to informed consent to guide staff; b) ensure all residents have a signed admission agreement in place as per the ARC contract.

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

Attainment and Risk: FA

Evidence:

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interview with the management team confirms practice.
D4.1d; Relatives interviewed (five) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy services.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D3.1h: Relatives interviewed (five) confirm they can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility.
D3.1.e Discussion with two caregivers, the activities staff, and relatives (five) confirm residents are supported and encouraged to remain involved in the community and external groups.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Complaint forms and a copy of the complaints process is available in the reception area. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. A complaints folder is maintained and all individual complaints (written and verbal) are documented. There has been one verbal complaint in March 2013, which has been investigated and a response provided to the complainant in a timely manner. Complaints are signed off. The complaints folder and register is kept up to date with evidence of follow up and resolution. Two caregivers, one registered nurse, one administrator, one owner/director (RN) and one manager confirm that all complaints are reported and recorded. The complaints register is included in the complaints, compliments, incident monthly analysis. All complaints, with corrective actions and outcomes are included in the quality analysis.

Resident/family satisfaction survey is conducted annually with random selection of participants. Family surveyed advised that they were more than satisfied with the care and services they receive as sighted in 2013. Results for 2014 are being collated.

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

E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

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

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

Attainment and Risk: FA

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:

Lakewood rest home provides dementia specific care for up to 36 residents with 35 residents on the day of audit. There is one respite resident. Lakewood is privately owned. A manager (diversional therapist) is responsible for day to day running of the home with clinical oversight provided onsite full time by the owner/director (RN). There is an administrator to assist with business planning who is a social worker. Lakewood has a quality assurance and risk management programme in place. The owner/director and manager meet daily to discuss clinical management and quality and risk management. There is a business plan for 2012 -2014 (reviewed November 2013) that includes a mission statement and operational objectives. The objective is to run a business that provides a high standard of care to its clients and provides a safe pleasant working environment for its employees. The services purpose and philosophical statement "we nurse residents with the aim of maintaining or restoring maximum independence in their functions of daily living and delivering quality, holistic care incorporating a strong sense of empathy, dignity and regard to individual rights, needs and wishes without discriminating against race, religious or sexual beliefs". There is a risk management schedule and documented quality objectives that align with the identified values and philosophy. The company states "We believe that all care and service must be delivered with compassion, professionalism and empathy and within the practice of Quality Assurance. The company will effectively manage the risks to its operations to ensure the on-going smooth operation of the company without detriment to its clients or staff. The company will manage a risk management policy that identifies the risks to the operation of the business and identified strategies to either minimise the risk or to contain and deal with the risk if it becomes reality. This includes an assessment of known workplace hazards and the hazard minimisation or eradication strategies used by the company an annual review of the quality programme is conducted by the owner/director, administrator, manager and registered nurse. Objectives are reviewed by the management and discussed at the monthly staff meetings. There is an internal audit plan. Audits include a summary, any issues arising and corrective actions when required. These are followed through in monthly staff meetings which incorporate management, quality improvement, infection control, health and safety and restraint (# link 1.2.3.6). Resident and family satisfaction is gauged through twice yearly resident meetings, annual relative's survey, food survey, complaints, compliments and suggestions.

ARC,D17.3di (rest home), The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. She has attended and completed a management course in 2012, has attended older person health/provider forums and peer support groups for managers (2014), has attended an elder abuse seminar (2014) and has maintained medication competency and wound competency 2014. The owner/director (RN) has attended InterRAI training 2014 and is to attend the dementia conference November 2014.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

During a temporary absence of the owner/director (RN) the manager oversees the service with clinical matters covered by the registered nurse.

D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001 (# link 1.2.3.3).

D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies (# link 1.2.3.3).

D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g Falls prevention strategies such as falls risk assessments, safe mobility and transfers, hazard free environment, appropriate equipment including beds, mobility equipment and seating.

The service has a business plan/quality management plan 2012-2014 (reviewed November 2013) that are implemented. Risk management schedule includes environment and equipment; resident safety; outside contractors; kitchen; laundry; staff safety, adverse events and emergency preparedness; financial; and legal liability. There are quality goals for 2014 with measurable outcomes documented. Achievement is measured by resident surveys (2014), complaints management, audits, monitoring of adverse events, and meetings minutes. Advised that the administrator has the role of quality coordinator with the manager now starting to take over some of this role. There is an internal audit schedule and internal audits are completed. Internal audits completed in 2014 included but not limited to; care planning, building compliance and building safety and hazards (January), cleaning, skin assessment, resident post admission (February), fire safety (March), resident rights and care planning (April), laundry and medications (May), IPC, informed consent, disturbed behaviour and clinical records (June), restraint, resident post admission and care planning (July), staff education and pressure area (August) and fire safety (September). Progress with the quality improvement plan is monitored through management meetings and monthly staff meetings.

The quality/management/staff meeting agenda includes (but is not limited to): occupancy, accidents/incidents, infection control, complaints/compliments, clinical issues, audit results, and education and training. This is an area requiring improvement. Minutes are kept and corrective actions are documented from issues arising. Staff meeting minutes for August and September 2014 were sighted. Agenda items include a report from management meeting as well as staffing, complaints/compliments, equipment, restraint, health and safety and training. Minutes are maintained and easily available to staff in a folder. Discussions with one registered nurse and two caregivers confirm their involvement in the quality programme. The service holds resident/relative meetings twice a year, and these are minuted (11 September 2014). Five family members interviewed stated they have the opportunity to talk to management or staff and are able to request changes if needed. Family members also stated that they are contacted if there are changes in a resident's health status.

The service has a document control system whereby all policies and procedures are reviewed annually however there are a number of policies that have not been reviewed annually including but not limited to a number of policies in the nursing sections 1-16 and 17-34. This is an area requiring improvement. The service has engaged the services of an employee from one of its other facilities (recently closed) to review all policies and procedures and ensure they are all reflective of current practice. Documents no longer relevant to the service are removed and archived. Policies reviewed are specific to Lakewood and staff are knowledgeable in regards to policy and procedures. Staff are encouraged to sign when they have read and understood any changes to documents. Updated policies are discussed at staff meetings as evidenced in meeting minutes reviewed for August and September 2014.

Quality improvement data is analysed to identify trends and themes including incidents, infections, hazards, and complaints however incident and infection trends are not evidence as being fed back to staff. The service continues to maintain the quality programme and improve on aspects of service delivery.

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: PA Low

Evidence:

The service has a document control system whereby all policies and procedures are reviewed annually.

Finding:

There is no documented evidence that all policies have been reviewed at regular intervals as evidence in nursing sections 1-16 and 17-34

Corrective Action:

Ensure that all policies are reviewed at regular intervals/annually.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The quality/management/staff meeting agenda includes (but is not limited to): occupancy, accidents/incidents, infection control, complaints/compliments, clinical issues, audit results, and education and training. Minutes are kept and corrective actions are documented from issues arising. Staff meeting minutes for August and September 2014 were sighted. Agenda items include a report from management meeting as well as staffing, complaints/compliments, equipment, restraint, health and safety and training. Minutes are maintained and easily available to staff in a folder. Discussions with one registered nurse and two caregivers confirm their involvement in the quality programme.

Finding:

There is no documented evidence that resident data regarding incidents/accidents and infections have been discussed/reported to staff.

Corrective Action:

Ensure that all quality data is available and fed back to staff.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.3b There is an accident/incident policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise risk and debriefing. There is an accident/incident register, electronic forms and monthly summaries are conducted. Incidents, accidents and near misses are investigated. Corrective actions are identified and these are followed through to ensure implementation. Incidents are analysed on a monthly basis and discussed at the two monthly quality meetings (# link 1.2.3.6).

Discussions with the owner/director and manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required. There is an open disclosure policy. Five family members interviewed stated that they are kept fully informed. Incident forms have a section to indicate if family have been informed (or not) of an incident/accident. Ten incident/accident forms were reviewed for August and September 2014. All demonstrated that there was clinical follow up by the owner/director (RN) or the registered nurse and the quality coordinator. In all cases where it is appropriate, contact with families after an incident/accident is documented either on the incident/accident form or in progress notes.

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: FA

Evidence:

Lakewood rest home employs 25 permanent staff. There are appropriate human resource policies and procedures in place for staff recruitment, training and support including staff recruitment policy, recruitment interviewing guidelines, interview questions, termination of employment policy, staff orientation policy with orientation pack and competencies, Police vetting form, staff conduct policy and form - signed by staff on commencement of employment and a non-disclosure of information form. Individual employment agreements were sighted in five of five staff files reviewed. There are job descriptions available for all positions and staff advised that they have employment contracts. Five staff files were reviewed (one registered nurse, one care giver, one activities coordinator, one cook and one manager). The owner/director conducts annual performance appraisals, and all five staff files evidenced up to date appraisal. Advised by owner/director that the manager is responsible for recruitment of staff. There is evidence of documented reference checking in the latest caregivers file to be employed. A copy of qualifications and annual practising certificates including registered nurse and general practitioners is kept and these were sighted for all GP's and registered nurses. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The orientation policy and programme includes care staff, cleaning, laundry, kitchen and registered nursing staff. Orientation includes infection control, health and safety, fire and evacuation, house rules, code of conduct and dress code, and responsibilities. Caregivers (two) and registered nurse (one) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There is a staff training policy and a staff performance monitoring policy. Discussion with the registered nurse and two caregivers confirm that the service provides in-service training and education that covers relevant aspects of care and support and meets requirements. The education programme for 2014 included (but not limited to); sexuality & aging, privacy & dignity (February), first aid, communication, falls prevention and communication (April), fire evacuation and continence (May), challenging behaviour, respect, open disclosure, documentation and health & safety (July), IPC (August), chemical use, informed consent hand washing, resuscitation & advanced directives and restraint (September). Training sessions are conducted by external providers and by the owner/director (RN). There is an education plan for 2014. The annual training programme exceeds eight hours annually. Caregivers interviewed (two) advised that they have either completed the ACE programme or an equivalent qualification. Two caregiver files reviewed evidenced completion of the ACE programme or National certificate in care of the elderly.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication management and insulin competency.

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

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

E4.5f: There are 16 caregivers, 12 have completed the required dementia standards, four caregivers are in the process of completing.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home. The owner/director (RN) provides clinical oversight and works 40 hours per week. The manager (also a DT) is employed for 40 hours per week and provides day to day management and quality assistance. A registered nurse works rostered hours of 24 hours per week and provides cares as well as registered nurse activities. There are two caregivers on the morning shift as well as the housekeeper and laundry staff member that assist with caregiving. There are four caregivers on the afternoon shift and two caregivers on night shift. There are designated staff for kitchen, laundry, cleaning and activities.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care plan is also developed in this time (# link 1.3.3.3). Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Five of six resident files sampled evidence that there are gaps in the progress notes of up to 10 days (link 1.3.3.3).

D7.1 Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Policies contain service name.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Five family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Admission agreements are signed and in place for four of six resident files sampled (link #1.1.10.4). The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

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

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

Attainment and Risk: PA Low

Evidence:

There is a policy and process that describe resident's admission and assessment procedures. A registered nurse undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission, and a long term care plan has been developed within three weeks of admission for five of six resident files reviewed. Improvement is required in this area. In all resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Care plan and risk assessment reviews are conducted by the registered nurse with input from the care staff, the activities staff and any other relevant person. These reviews have occurred for five of five permanent resident files (one respite), however, these have not occurred within the expected timeframes for four of five permanent resident care plans. Improvements are required in this area. Activities assessments and care plans are developed by the activities coordinator. Handover occurs at the end of each duty that maintains a continuity of service delivery. There is a communication book which staff read that includes reviewed policies. The registered nurse provides on-call and after hours and weekends cover.

Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of five permanent resident files sampled (of six – one respite). It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be

seen three monthly. GP interviewed stated that the service contacted him in a timely fashion, providing him with information required to assess his residents. The service carried out any observations and interventions he prescribed. Five of six resident files sampled evidence that there are gaps in the progress notes of up to 10 days and an improvement is required in this area.
There is a range of assessment tools available for completion including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment and f) challenging behaviours (link finding #1.3.4.2). The InterRAI assessment tool is not yet in use. Long term care plans reviewed for five residents' evidence comprehensive and resident focused goals and interventions. All five files identified integration of allied health including podiatry.
Six resident files were sampled and included one resident with a wound, one on controlled drugs and weight loss, one with behaviours which require further specialist input, one respite resident, one Maori resident, and one resident under the age of 65.

Tracer methodology:

Resident admitted February 2014 with a history of Korsakov's dementia, enlarged prostate and indwelling catheter due to urinary retention. The resident is estranged from immediate family and a court appointed welfare guardian is in place. The resident's behavioural and psychological symptoms of dementia have been deteriorating over the past few months as evidenced in progress notes reviewed and on interview with the RN, RN/owner and GP. The resident has become more withdrawn, has voiced suicidal thoughts, at times is refusing to eat and drink, does not cope with his catheter, and is at times verbally and physically aggressive to staff and residents. The incidents of these behaviours have become more frequent and resident is spending more and more time in bed. The resident was observed in bed on both audit days. On interview, the GP advised that he has been conducting regular reviews of the resident's medication. Symptom control has been attempted with haloperidol and respiradone. The GP has been adjusting doses of haloperidol and respiradone to reduce the Parkinsonian like side effects which the resident exhibits. The service referred the resident to psychiatric services for the elderly for medication review some months ago but was not considered a priority. The RN's and GP feel that resident has a significant level of depression, however, antidepressant medication is not working. A further referral was sent on the 2 October 2014 for urgent review of this resident. Care staff and activities staff interviewed advice that they are aware of the resident's mood and behaviours. They try and encourage him to shower and dress, eat and drink and to attend the lounge for activities and company. The staff are monitoring the resident's urine output. The resident was taken out on an outing by a close friend on the evening of the first day of audit.

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: PA Low

Evidence:

There is a policy and process that describe resident's admission and assessment procedures. A registered nurse undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission, and a long term care plan has been developed within three weeks of admission for five of six resident files reviewed. In all resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Care plan and risk assessment reviews are conducted by the registered nurse with input from the care staff, the activities staff and any other relevant person. The risk assessment reviews have occurred for five of five permanent resident files (one respite), however, these have not occurred within the expected timeframes for four of five permanent resident care plans. Activities assessments and care plans are developed by the activities coordinator.

Finding:

a) One resident did not have an initial assessment and long term care plan developed within the expected time frames. The resident was transferred from another facility and the previous assessments and care plan were utilised for four months before new assessments and care plans were developed; b) four of five permanent residents have not had risk assessment reviews completed within the expected timeframes; c) Five of six resident files sampled evidence that there are gaps in the progress notes of up to 10 days

Corrective Action:

a) and b): ensure all assessments, care plans and reviews are conducted within the expected time frames as per the ARC contract; c) Ensure that all residents' progress notes are written more frequently

Timeframe (days): 90 *(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: PA Low

Evidence:

An initial nursing assessment is completed within 24 hours of admission (with exceptions link #1.3.3.3). The initial assessment includes: activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, social history, and level of personal ability, skin integrity, sexuality/privacy, spirituality/values/beliefs, and an orientation to the facility check list. Personal needs outcomes and goals of residents are identified. There is a range of risk assessment tools completed on admission and reviewed six monthly (with exceptions link finding #1.3.3.3) if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment, f) challenging behaviours. The interRAI assessment tool is yet to be utilised. Improvements are required in relation to completion of all required assessments. Assessments are conducted in an appropriate and private manner. All five relatives interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Five family members stated they were informed and involved in the assessment process.

The assessment tools link to the individual care plans. The care plans are individualised for each resident need such as (but not limited to): mobility, falls risk, communication, night pattern, clothing, hair/nail care, medications, infection issues, memory loss/confusion, elimination, spirituality, safety, controlling pain, wound management, skin care, dietary needs, hygiene, oral care, cultural needs, mood, behaviours, personal preference, and family/advocate information. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.

The general practitioner completes a medical admission with two working days. Families interviewed confirmed their involvement.

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: PA Low

Evidence:

An initial nursing assessment is completed within 24 hours of admission (with exceptions link #1.3.3.3). The initial assessment includes: activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, social history, and level of personal ability, skin integrity, sexuality/privacy, spirituality/values/beliefs, and an orientation to the facility check list. Personal needs outcomes and goals of residents are identified. There is a range of risk assessment tools completed on admission and reviewed six monthly (with exceptions link finding #1.3.3.3) if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment, f) challenging behaviours. The interRAI assessment tool is yet to be utilised. Assessments are conducted in an appropriate and private manner. All five relatives interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Five family members stated they were informed and involved in the assessment process.

Finding:

a) Wound assessments are incomplete or not done at all for three of six residents with wounds; b) challenging behaviour assessment has not been completed for a resident displaying documented aggressive behaviours; c) one respite resident has an incomplete initial assessment. A comprehensive short term care plan is in place for this resident.

Corrective Action:

a) Ensure all residents with wounds have a wound assessment completed; b) ensure those residents who display challenging behaviours are appropriately assessed; c) ensure all respite residents have initial admission assessments completed.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Residents' files include; resident information and family contact sheet, initial nursing assessment, initial care plan, daily progress notes, observations chart, short term care plans, long term care plans, risk assessments, GP medical notes, lab results, allied health reports, activities, consents, advance directives, letters, discharge summaries, and NASC assessment.
The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. Long term care plans are individually developed with the resident and family/whanau. Five family members interviewed stated they are involved in the care planning process. Nursing diagnosis, goals, interventions and outcomes are identified. The care plans are individualised for each resident need such as (but not limited to): mobility, falls risk, communication, night pattern, clothing, hair/nail care, medications, infection issues, memory loss/confusion, elimination, spirituality, safety, controlling pain, wound management, skin care, dietary needs, hygiene, oral care, cultural needs, mood, behaviours, personal preference, and family/advocate information. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.
There is evidence that residents are seen by the GP at least three monthly. Activities and diversional therapy documentation includes an activities profile, an activities plan with generic areas of care, activities attendance records and weekly progress notes. On review of permanent resident files (five of six) it is noted that the plans do not include specific activities or diversional therapies which cover the 24 hour period. Improvements are required in this area.
Short term care plans are used for acute changes to health e.g. urinary infection, chest infection, wounds and pain.

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

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

Attainment and Risk: PA Low

Evidence:

The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. Long term care plans are individually developed with the resident and family/whanau. Five family members interviewed stated they are involved in the care planning process. Nursing diagnosis, goals, interventions and outcomes are identified. The care plans are individualised for each resident need such as (but not limited to): mobility, falls risk, communication, night pattern, clothing, hair/nail care, medications, infection issues, memory loss/confusion, elimination, spirituality, safety, controlling pain, wound management, skin care, dietary needs, hygiene, oral care, cultural needs, mood, behaviours, personal preference, and family/advocate information. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.
There is evidence that residents are seen by the GP at least three monthly. Activities and diversional therapy documentation includes an activities profile, an activities plan with generic areas of care, activities attendance records and weekly progress notes.

Finding:

On review of permanent resident files (five of six), it is noted that neither the long term care plan nor the activities plan includes specific activities or diversional therapies which best manages the resident's behaviour over a 24 hour period (as per the ARC contract).

Corrective Action:

Ensure that each resident's care plan includes behaviour management strategies (including diversional therapies) which cover a 24 hour period.

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lakewood rest home provides services for residents requiring dementia rest home level of care. Individualised care plans are completed. The two caregivers and one registered nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment. Medical equipment does require calibration as per finding #1.4.2.1.

Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.
There are currently six residents with wounds which include skin tears (four), ulcers (five) and one split natal cleft. Wound assessments are completed for three of the six residents with wounds (link finding #1.3.4.2). Wound management plans, progress and evaluations are completed for all wound plans reviewed.
Five family members interviewed confirm their current care and treatments their family members are receiving meet their needs.

Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed.
All falls are reported on the resident accident/incident form and reported to the registered nurse or owner/registered nurse. Falls risk assessment is completed on admission and reviewed should there be an increased falls risk. A physiotherapist referral can be initiated as required.
There is one part time registered nurse employed by the service who attends the facility three days per week. The owner is also a registered nurse and provides weekend cover and during the week if required. A record of all health practitioners practicing certificates is kept.
Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status.
During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.
Short term care plans are in use for changes in health status.

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:

The activities programme is provided for six days a week, 9am – 5pm (7.5 hours per day). There are two activities coordinators – both have completed the ACE training programme and one has just completed her diversional therapy training. One activities coordinator works 36 hours per week from Monday to Friday and the other coordinator works for 24 hours per week from Tuesday to Saturday. A care giver provides activities on a Sunday. There is a monthly activity planner. The programme reflects the resident's interests and abilities and they have choice in their level of participation. Activities include (but are not limited to): exercises, newspaper reading, floor games, entertainment, walks, quizzes, and reminiscing, seasonal celebrations, arts and crafts, baking, and knitting. Specific activities are provided for individual residents reflecting their interests and need for diversional therapies. These include one to one time, flower arranging, completing house hold tasks, gardening, doll therapy, and use of music. One-to-one support is provided in situations where residents are unable to participate in group activities. Residents have an activities and social profile completed on admission, an activities plan which includes generic goals and progress notes are maintained on a weekly basis. The care plans do not include a plan to best manage challenging behaviours over a 24 hour period as per finding #1.3.5.2.

Attendance records are kept. Five family interviewed spoke positively of the programme. Activities are regularly evaluated with residents and family to ensure that the activity programme is appropriate for the residents who currently reside at Lakewood. The activities coordinators stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions.
Resident files reviewed identified that the individual activity plan is reviewed at same time as care plan review occurs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

All initial care plans were developed by a registered nurse on day of admission (with exceptions link finding #1.3.3.3) and resident comprehensive long term care plans developed within three weeks of admission. Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were up to date in all five permanent resident files sampled. Changes in health status trigger an update on the long term care plan. Care plan reviews are signed as completed by a RN. GP's review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the management of the residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

The service facilitates access to other medical and non-medical services. The RN interviewed advised that the GP signs off on any referrals after consultation with family. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted. One resident has been referred to psychiatric services for the elderly for medication review.
Relatives interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.
There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice, however, evidence of regular policy reviews are required as per finding #1.2.3.3.
The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP.
Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and PRN medication. It is noted on review of 12 medication charts and administration signing sheets that caregivers have been administering an evening dose of insulin without a current medication order and one dose of a B12 injection was given outside the prescribed time frame. Improvements are required in this area.
Due to the acuity of the residents at Lakewood, no residents self-medicate their own medications.
The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents' medication charts and resident files on the front page. There is a staff signature identification sheet

in the front of the medication folders.
Two medication rounds (lunch time and evening meal) was observed and two caregivers followed correct administration procedures.
There is a controlled drug safe in the locked treatment room and there is a controlled drug register - with one resident on PRN controlled drugs. There is evidence that two staff sign out all controlled drugs. It is noted on review of the controlled drug register that weekly stock checks have not been conducted and that the controlled drug key to the safe was left in the lock. The key was immediately removed and placed on the medication competent staff member's key ring. A system of signing over the keys at shift change was instigated on the first day of audit. The service has a medication fridge which required temperature monitoring. Improvements are required in these areas.
Lakewood rest home uses the Webster Pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy.
There was evidence that all medication competent care staff have completed annual competencies. Improvements are required whereby the RN also completes annual medication competency. Medication training was last provided in May 2013.
Medication audits are conducted.
Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Moderate

Evidence:

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP.
Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and PRN medication there is a staff signature identification sheet in the front of the medication folders.
Two medication rounds (lunch time and evening meal) was observed and two caregivers followed correct administration procedures.
There is a controlled drug safe in the locked treatment room and there is a controlled drug register - with one resident on PRN controlled drugs. There is evidence that two staff sign out all controlled drugs. Lakewood rest home uses the Webster Pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. .

Finding:

a) Caregivers have been administering an evening dose of insulin without a current medication order. The resident had a new medication chart written up by the GP on 14 August 2014. The resident had previously been given two daily doses of insulin as per the GP instructions, however, when the new chart was written up, the evening dose of insulin had inadvertently been left off the medication chart. Care staff had continued to administer the evening dose without an order. The medication chart was rectified by the GP on the day of audit to reflect the correct order; b) on review of one resident medication order and

administration signing sheet, it was noted that one dose of a B12 injection was given outside the prescribed time frame (at a five month interval instead of three monthly); c) weekly checks of controlled drugs has not occurred; d) the key to the controlled drug safe was observed to be left in the lock – this was removed on the day of audit and placed on the medication competent staff member's key ring. A system of signing over the keys at shift change was instigated on the first day of audit; e) the medication fridge has not had temperature monitoring conducted.

Corrective Action:

a) ensure that correct procedures are followed when administering medications; b) medication must be administered according to general practitioners instructions; c) conduct weekly checks of the controlled drugs and record in the controlled drug register; d) ensure that the safety and security of controlled drugs are maintained at all times; e) provide evidence that the medication fridge is monitored for safe temperatures.

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

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

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

Attainment and Risk: PA Low

Evidence:

There was evidence that all medication competent staff have completed annual competencies. Medication training was last provided in May 2013.

Finding:

The registered nurse has not completed an annual medication competency.

Corrective Action:

Ensure that all staff who administer medications have annual medication competencies completed.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a small functional kitchen at Lakewood. All food is cooked on site. The service employs two cooks who are supported by care staff. Kitchen staff have completed safe food handling certificates. A cleaning schedule is maintained. There is a large walk in chiller in the kitchen and a freezer in a storage area. The kitchen has a well-stocked pantry, electric cooker, electric oven and microwave. The service has a four week winter and summer menu that was

last reviewed by a dietitian in November 2013. Resident files reviewed show evidence of nutritional assessments being conducted on admission. Dietary information is documented in the care plan and verbally handed over to kitchen staff.
Resident weights are monitored monthly and the service is able to utilise a dietitian for weight loss should this be required. There is evidence of residents receiving supplements and high protein/high calorie diets. Residents displaying weight loss are reviewed and monitored by the general practitioner. The daily menu is posted in the dining room. Fridge and freezer temperatures are monitored daily and recorded monthly. Food in the fridge and freezers is covered and dated. An improvement is required in relation to dating decanted foods in the dry store pantry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

All food is cooked on site. The service employs two cooks who are supported by care staff. Kitchen staff have completed safe food handling training. A cleaning schedule is maintained. There is a large walk in chiller in the kitchen and a freezer in a storage area. The kitchen has a well-stocked pantry, electric cooker, electric oven and microwave. The daily menu is posted in the dining room. Fridge and freezer temperatures are monitored daily and recorded monthly. Food in the fridge and freezers is covered and dated.

Finding:

On a tour of the kitchen, it is noted that decanted dry goods in the pantry are not dated with best before or expiry dates.

Corrective Action:

Ensure all decanted dry goods are stored appropriately, labelled and dated with an expiry date or best before dates.

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals. Chemicals are stored in a locked storage cupboard in laundry until required. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with two caregivers, one cleaner and one laundry person described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in September 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The service displays a current building warrant of fitness which expires on 1 June 2015. There is an approved evacuation plan dated 9 June 2005 and fire drills are completed six monthly. Maintenance is conducted as required. Medical equipment and scales have not been calibrated by an authorised technician. Improvements are required in this area. Hot water temperatures checks are conducted and recorded monthly by the co-manager. Hot water temperatures are recorded and are consistently recorded between 43 and 45 degrees Celsius. Renovations and earthquake repairs have recently been completed and the interior is well maintained with a home-like décor and furnishings. There is a large communal lounge, dining area, and communal bathroom and toilet facilities. There are small seating nooks available for residents and visitors. The corridors are wide with handrails in place. There is an external area which residents can safely access. There is easy access to the outdoors. Outdoor ramps have handrails. The unit has a secure garden. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with two caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The service displays a current building warrant of fitness which expires on 1 June 2015. Maintenance is conducted as required. Hot water temperatures checks are conducted and recorded monthly by the co-manager. Hot water temperatures are recorded and are consistently recorded between 43 and 45 degrees Celsius. Electrical equipment has been tested and tagged (August 2014). Renovations and earthquake repairs have recently been completed and the interior is well maintained with a home-like décor and furnishings.

Finding:

Medical equipment and scales have not been calibrated by an authorised technician.

Corrective Action:

Ensure that all medical equipment is calibrated and checked by an authorised technician.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

A number of residents have shared ensuite facilities. The number of communal toilets and showers provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Toilets and showers have signage and privacy locks. Family interviewed state their resident's privacy and dignity is maintained while attending to their personal cares and hygiene.
Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvred mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a large lounge and dining room, a smaller lounge and dining area and a library/quiet room in the facility. The dining rooms are spacious and located directly off the kitchen/servery area. Food is plated and served directly to residents in the dining room at meals times. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lakewood rest home has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer's data safety charts are available. Five family interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Laundry audit conducted in May 2014 and cleaning audit conducted in February 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Appropriate training, information, and equipment for responding to emergencies is provided (December 2013). Fire evacuations are held six monthly and the last drill was completed May 2014, noting this was an actual drill. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible and includes torches, batteries, lamps, hi-viz vests and radios in two boxes. The kit has been checked 12 February 2014. The facility is well prepared for civil emergencies and has emergency lighting, a generator, stored water and access to an adjacent artesian well, gas stove, gas heater and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas - indicator panels are in the newly built Rose wing.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Five family interviewed state the environment is warm and comfortable.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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:

Lakewood has comprehensive policies and procedures on restraint minimisation and safe practice. The registered nurse and owner/registered nurse work together as the restraint coordinators and both confirm that the service promotes a restraint-free environment.
There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has one resident assessed as requiring the use of restraint (bed rails for falls prevention), one resident assessed as requiring PRN restraint (lazy boy chair or chair with table for falls prevention) and no enablers. The care plans reviewed for both residents with restraint includes completed restraint assessment. Safety and risk assessments have been conducted and both restraints are used to prevent falls due to unsafe behaviours. On-going consultation with the GP and family/whanau is also identified (confirmed on interview). Falls risk assessments are completed six monthly. Policy dictates that enablers should be voluntary and the least restrictive option possible and the registered nurse, two caregivers and the owner/registered nurse are familiar with this.
Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring

forms, and three-monthly evaluation forms. Restraint education last provided for staff in September 2014 with associated questionnaire and competency completed by 19 staff.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinators (RN's) were able to describe the role and responsibilities. Approval for each form of restraint is reviewed at a frequency as determined by organisational

Restraint Minimisation policy and resident safety. Two resident files, assessed as requiring restraint, were reviewed and evidenced consent form completed appropriately. This was confirmed on interview with one resident's family member. Restraint discussion is conducted at staff meetings. Restraint use is reviewed at resident level as part of staff meetings and at care plan reviews (or more often as needed). Last reviewed in July 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint minimisation and safe practice policy outlines the service's approach to managing restraint. The policy includes the steps for assessment and use of restraint, role of the restraint coordinator, involvement of family and GP, risk assessment, the need to attempt to modify behaviour prior to the use of restraint, resident advance directives, previous tolerance of restraint application, resident medical and social history, cultural considerations, alternatives to restraint use and the goals of the restraint intervention. Two resident files were reviewed - and evidenced that a documented restraint assessment, discussion and alternatives form has been completed. Family/whanau input and consent is required prior to the application of any forms of restraint at Lakewood. Advised that restraint is only used as a last resort, when the resident is restless and attempts to mobilise unaided (PRN chair restraint), and used infrequently as evidenced by restraint monitoring forms. One resident has bedrails placed on at night time to prevent her falling out of bed as she attempts to walk unaided. Prior to use of PRN restraint the resident is assessed and alternatives actioned.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

Restraint policy states that the need for restraint use is monitored and reviewed as part of the six monthly care plan reviews. On review of two files, this is well documented when restraint in the form of chair restraint or bed rails is used. Restraint use is documented with time frames and details of monitoring of

the chair restraint or bed rails in place. Monitoring occurs at 15 minute intervals when the lap belt is in use while the resident is in a wheel chair and at least two hourly when bed rails are used. Monitoring of restraint is recorded in progress notes and evidence that the restraints have been used nightly for one resident with bed rails and once in 2014 for the resident with the chair restraint. The service reviews all restraint use as part of the individual care plan review. Restraint is only used at Lakewood as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. Advised that the restraints currently in use are for safety measures to prevent falls. This is outlined as policy requirements in the restraint minimisation and safe practice policy. A restraint register is maintained with the resident's name and restraint details included. Staff training records are maintained and individual participation in restraint training is identified. Restraint questionnaire and competencies are completed by all care staff.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use

of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The use of restraining devices is evaluated by the restraint coordinators (owner/RN and registered nurse) as part of the care planning review process in conjunction with the family/whanau and GP. Points a) to k) above are considered as part of this review. On review of two resident files, both forms of restraint, have been reviewed three monthly as per policy. Restraint use and approval is discussed at the staff meetings and is appropriate for size and complexity of the service.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lakewood reviews the use of restraint as part of its internal audit processes as per the audit schedule in place (last conducted in 16 July 2014). The results of the restraint audit are discussed at the staff meetings where restraint use and approval is discussed. Any corrective actions identified are actioned through these forums.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. There is a job description for the infection control coordinator who is the owner/director. There is an implemented infection control programme that is linked into the quality management system. The infection control programme is reviewed annually. The facility has access to GPs, local Laboratory, the infection control and public health departments at the local DHB for advice. Infection control matters are taken to the monthly staff meeting however there is no feedback to staff regarding collated data of infection rates (# link 1.2.3.6).

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control team is the owner/director, registered nurse and enrolled nurse with the owner/director taking the lead. The facility also has access to infection control nurse specialist, district health board specialists, public health and GP's.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures. Policy review involves the infection control coordinator and the management team (last reviewed 2013).The service subscribes to “Bug Control “policies and current policies 2014 sighted in use.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed appropriate IC training through a CPIT course in Christchurch. The orientation package includes specific training around hand washing. The IC coordinator provides training both at orientation and on-going. Training on infection control is included in as part of the training schedule and last provided August 2014 and 15 staff attended. Monthly surveillance audits also include opportunistic education with staff. Resident education is expected to occur as part of providing daily cares.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly summary sheet completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and discussed with management team (# link 1.2.3.6). The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The service reports having no outbreaks within the last two years.

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.)*