

# Harbour View Rest Home (2005) Limited

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Current Status: 28 October 2014

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

## General overview

Harbour View rest home is owned and operated by a husband and wife team. One owner is the designated manager. The manager is supported by a clinical coordinator, registered nurses and care staff. The service is certified to provide rest home and dementia care for up to 44 residents.

Harbour View has clearly defined goals and objectives for business management and resident service delivery. Annual review of the quality and risk management programme is conducted. The manager has been in the role for over 12 years and is an experienced health administrator. Residents and families interviewed were complimentary of the care and support provided.

The service has addressed six of eight previous shortfalls relating to ensuring professional boundaries are maintained; clinical follow up of incidents and accidents; medication competencies; appraisals for registered nurses and orientation to the dementia unit programme; use of corrective fluid on documentation; assessments for clinical risks and wounds and aspects of care plan documentation. Further improvements remain required in relation to assessments and aspects of wound care plans. This audit also identified that improvements are required around aspects of medication management.

## Audit Summary as at 28 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
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

### Consumer Rights as at 28 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.		Standards applicable to this service fully attained.
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### Organisational Management as at 28 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.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 28 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.
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### Safe and Appropriate Environment as at 28 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.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 28 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.
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## Infection Prevention and Control as at 28 October 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Harbour View Rest Home (2005) Limited		
<b>Certificate name:</b>	Harbour View Rest Home (2005) Limited		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Harbour View Rest Home		
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care		
<b>Dates of audit:</b>	<b>Start date:</b> 28 October 2014	<b>End date:</b> 29 October 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			43

## Audit Team

<b>Lead Auditor</b>	XXXXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	4
<b>Other Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>				<b>Hours</b>	

## Sample Totals

Total audit hours on site	12	Total audit hours off site	4	Total audit hours	16
Number of residents interviewed	5	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	30	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXXXX, 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	Yes
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 Thursday, 13 November 2014

## Executive Summary of Audit

### **General Overview**

Harbour View rest home is owned and operated by a husband and wife team. One owner is the designated manager. The manager is supported by a clinical coordinator, registered nurses and care staff. The service is certified to provide rest home and dementia care for up to 44 residents. On the days of audit there were 26 rest home residents (including one respite) and 17 residents in the dementia unit. Harbour View has clearly defined goals and objectives for business management and resident service delivery. Annual review of the quality and risk management programme is conducted. The manager has been in the role for over 12 years and is an experienced health administrator. Residents and families interviewed were complimentary of the care and support provided.

The service has addressed six of eight previous shortfalls relating to ensuring professional boundaries are maintained; clinical follow up following incidents and accidents; medication competencies, appraisals for registered nurses, and orientation to the dementia unit programme; use of corrective fluid on documentation; assessments for clinical risks and wounds; and aspects of care plan documentation.

Further improvements are required in relation to assessments and aspects of wound care plans.

This audit identified that improvements are required around aspects of medication management.

### **Outcome 1.1: Consumer Rights**

The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The previous audit finding relating to upholding professional boundaries has been addressed and monitored. Communication with residents and families is conducted and recorded. Complaints and concerns are actively managed and documented. A complaints register is maintained.

### **Outcome 1.2: Organisational Management**

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following audits. Key components of the quality management system link to monthly management meetings and monthly staff meetings. Residents meetings are held six weekly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. Reporting of and investigations into incidents and accidents occurs, including clinical follow up of residents with an injury. The service has made improvements in this area. There is an induction programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. Registered nurses performance appraisals align with current nursing competencies and all registered nurses and senior caregivers complete medication competencies. New care staff receive an orientation to the dementia unit. The service has made improvements in these areas. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

**Outcome 1.3: Continuum of Service Delivery**

The registered nurses (RN) and/or clinical coordinator (RN) are responsible for each stage of service provision and there is evidence that of resident/family/whanau involvement in the care planning process. Risk assessments are completed and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. Improvements are required whereby an initial assessment is completed for all residents and wound care plans provide sufficient detail. Short term care plans and evaluation of short term care plans for short term needs and long term care plans is conducted. The service has addressed and monitored this previous shortfall. The residents' needs, interventions, objectives/goals have been identified in the long term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. Nursing care evaluations are signed and dated by the registered nurse completing the review. The service has made improvements in this area. There is evidence in the resident files that there is resident and/or family/whanau input into the development and review of care plans. Resident files are integrated and include notes by the general practitioner (GP) and allied health professionals.

There is a varied and interesting activity programme of activities, outings and entertainment that meets the group and individual interest, abilities and preferences. Community links are maintained and there are a number of volunteers who interact socially with the residents.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. Improvements are required whereby transcribing is ceased and all residents have a signed medication chart for every medicine administered.

Food services and all meals are provided on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

**Outcome 1.4: Safe and Appropriate Environment**

The building has a current building warrant of fitness which expires on 1 May 2015.

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

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit days.

**Outcome 3: Infection Prevention and Control**

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	17	0	2	1	0	0
<b>Criteria</b>	0	41	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	30
<b>Criteria</b>	0	0	0	0	0	0	0	57

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 planning.	PA Low	It is noted that an initial nursing assessment has not been completed for five of five resident files reviewed (three rest home and two dementia).	Provide evidence that initial assessments are conducted within 24 hours of admission.	90
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			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
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	It is noted on wound care documentation for seven residents with nine wounds, that comprehensive wound treatment plans and frequency of dressings is not recorded in sufficient detail. Advised by the RN that dressings are usually done on the days that the resident has a shower, however this is not recorded. Nine wound care plans have an assessment completed. The RN records the change of dressing but there is little evidence of a plan of care relating to which dressing products to use and how often the dressing should be changes. The progress of the wound is recorded on wound care documentation and in the computerised progress notes.	Ensure that each wound care plan records sufficient detail as to the type of care and products to be used and the frequency of the dressing.	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	PA Moderate	a)One respite	a)Ensure that all	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		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.		resident's medication chart (which has been generated by the pharmacy supplying the medication packs) has not been signed by the GP; b) A short course of medication has been given to the respite resident (now completed) without a medication order; c) It was noted that in two medication files, there is evidence of transcribing of medication orders. The RN has rewritten two medication orders on a piece of paper tucked in front of the medication chart to prompt care staff. These were removed on the day of audit.	medication charts are individually signed by the prescriber; b) Ensure that all medications administered have a corresponding signed order in place; c) Cease the practice of transcribing medication orders.	

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

### **Standard 1.1.7: 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:**

There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with five residents identify that privacy is ensured. Discussions with two caregivers described how professional boundaries are maintained. Discussions with the manager and a review of complaints identified no complaints of this nature. Previous audit identified the potential for professional boundaries to be crossed with a staff member residing in a down stairs area of the home where residents also resided. There are now no staff living on site and the down stairs area is occupied by rest home residents only. Six rest home residents live in the downstairs area including one married couple who share a room. All of these residents are able bodied and are able to manage the connecting stairs. The service did not renew the previous tenancy agreement and has addressed the previous finding.

### **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 1.1.9: 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 an open disclosure policy, a complaints policy, and an incident reporting policy. Five residents and four family members (one rest home and three dementia) stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur six weekly and the manager and clinical coordinator have an open-door policy.

All incident report forms sighted for September 2014 were completed and family notified as appropriate. Family notification is also recorded in progress notes and on a family contact sheet.

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: The four family members interviewed stated that they are always informed when their family member's health status changes or of any other issues

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. No complaints have been received over the past 12 months. Both verbal and written complaints are actively managed. There is a complaints register and this has been utilised for documenting past complaints or concerns. Five residents and four family members (one rest home and three dementia) advised that they are aware of the complaints procedure and how to access forms.

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 King George dementia 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. Complaints process.

### **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:**

Harbour View rest home is privately owned and operated by a husband and wife team. One owner is the manager. The service is certified to provide rest home and dementia specific care to up to 44 residents – 26 rest home and 18 dementia. On the days of audit there were 26 rest home residents including one respite and 17 dementia specific residents. Harbour View has clearly defined goals and objectives for business management and resident service delivery. The mission statement and vision and values of the services include promoting resident's independence, respecting cultural values and providing a caring homelike environment. Annual review of the quality and risk management programme is conducted. The manager has been in the role for over 12 years and is an experienced health administrator. The manager has attended in excess of eight hour's professional development in the past 12 months. The manager is supported by an experienced clinical coordinator who was absent on the days of audit.

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.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The management manual includes the business, quality and risk management plan and service philosophy. The quality programme is reviewed annually (last conducted February 2014). The quality and risk management plan has documented aims with implemented activities for each aim. Aims for the service include: a consumer focus, provision of effective programmes, certification and contractual requirements, risk management, and continuous improvement. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly management meetings, and monthly staff meeting. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Management meeting minutes sighted for August 2014 and staff meeting minutes for July 2014.

Minutes include actions to achieve compliance where relevant. Discussions with the registered nurse and two care givers confirm their involvement in the quality programme. Resident/relative meetings take place six weekly. Internal audits are conducted and include: safety, pressure area risk, recreation programme, care/hygiene of residents, infection control, challenging behaviour management, laundry service, cleaning, privacy of information, restraint, medication management and storage, building compliance, civil defence kit and care plan audit. Audits for 2014 have been completed and there is documented management around non-compliance issues identified.

Finding statements and corrective actions have been documented. A resident and family survey conducted in October 2014 evidences that families are over all very satisfied with the service. A survey evaluation has been conducted for follow up and corrective actions required. The service collects information on resident incidents and accidents as well as staff incidents/accidents. Quality improvements are documented as identified through the quality activities. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

D5.4 The service has policies and procedures to support service delivery; Policies and procedures align with the client care plans. The owner/manager is responsible for policy review. The policy manuals are reviewed annually.

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

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 include exercise programme, education for staff, residents and families, falls risk assessment, walking aids, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

**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:**

There is an accidents and incidents reporting policy. Accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at management and staff meetings including actions to minimise recurrence. Incident/accident forms are completed by caregivers and registered nurses (RN's) and given to the clinical coordinator who initiates any additional follow up. The manager collates and analyses data to identify trends. Discussions with the manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of incident reports for September 2014 were reviewed and involved three rest home and three dementia residents. Incident reports reviewed related to falls, skin tears and challenging behaviour incidents. There is evidence that neurological observations were conducted following an unwitnessed fall for two residents files reviewed. One resident was transferred to acute care. One dementia resident with two incidents of aggression/agitation has had appropriate review and follow up and has been referred for reassessment by a psychogeriatrician. One rest home resident who recently developed a sacral pressure area has had this reported via the incident reporting process. Risk assessments are reviewed including falls, pressure area risk and behaviour assessment and monitoring. Clinical observations are conducted. The service has addressed and monitored this previous finding. D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

### **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:**

There are human resource management policies in place which includes recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the clinical coordinator, registered nurses, dietitian, podiatrist and general practitioners is kept. The human resources policies also include orientation, staff training and development. Five staff files were reviewed (one clinical coordinator, one registered nurse, one rest home care giver, one dementia unit care giver, and one cook). Advised that reference checks are completed before employment is offered as evidenced in two recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in staff files reviewed.

Discussion with the manager, registered nurse and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Two caregivers interviewed have either completed the national certificate in care of the elderly or have either completed or commenced the aged care education programme. The clinical coordinator is responsible for facilitating the ACE programme with caregivers. The manager, clinical coordinator and registered nurses attend external training including conferences, seminars and sessions provided by the local DHB. Education has been provided as per the 2014 education planner. Fire evacuation drill last conducted 2 September 2014.

On review of five staff files, performance appraisals for four of five staff have been conducted (one cook has been employed within the past 12 months). The registered nurses appraisals align with the Nursing Council of New Zealand registered nurse competencies. The service has made improvements in this area. Medication competencies are conducted annually for all clinical staff with medication responsibilities. The competency package is tailored to care givers and is completed by registered nurses. The clinical coordinator has now completed a medication competency (February 2014). The medication competency package now include controlled drugs storage, administration and management. The service has made improvements in these areas.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication administration and syringe driver use.

E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies and this is now recorded on the orientation checklist. The service has made improvements in this area.

E4.5e: Agency staff are not utilised.

E4.5f: There are 12 caregivers who work in the King George Dementia unit, eight have completed the required dementia standards, one caregiver is in the process of completing and three are yet to start. Of those caregivers that are yet to start, all three have commenced employment within the last six months.

### **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 good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and dementia unit residents. At least two staff are rostered on at any one time with one staff (RN) on-call. The three registered nurses share the on-call. Advised that extra staff can be called on for increased resident requirements. Interviews with two caregivers, five residents and four family members (one rest home and three dementia) identify that staffing is adequate to meet the needs of residents.

### 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:**

D7.1 Entries in resident files are legible, dated and signed by the relevant care giver or RN including designation. Previous audit identified a finding relating to the use of corrective fluid the service no longer uses corrective fluid to amend documentation errors. Where an error is made, the person making the entry draws a line through the writing and initials it as evidenced in the resident files reviewed. The service has made improvements in this area.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy and process that describe resident's admission and assessment procedures. A registered nurse undertakes risk assessments on admission as evidenced in five files reviewed (three rest home including one respite and two dementia). On five of five files it is noted that an initial assessment has not been completed on which to base the initial and/or long term care plan (link finding #1.3.4.2). The long term care plan is developed within 24 hours for five of five care plans reviewed. The admission information, medical notes, allied health notes, progress notes, staff input, resident and family input form the basis of the long term care plan. The activities assessment is completed within two weeks of admission.

Residents retain their own GP's and there are a number of GP's that provide medical services.

A range of risk assessment tools completed on admission are evident in the five resident files sampled and include pain, falls risk, pressure area risk, continence and challenging behaviours.

There is a verbal handover between shifts and written handover sheet with resident significant events documented. Daily progress notes are written on the computer and are maintained.

All five files identified integration of allied health professionals including GP medical notes, podiatry notes, letters and referrals to other allied health professionals and specialists.

D16.2, 3, and 4: The five resident files reviewed identified that in all files risk assessment was completed within 24 hours and the long term care plan was completed within three weeks. There is documented evidence in resident files sampled that the care plans are reviewed by an RN.

Resident files sampled evidenced written evaluations are completed, dated and signed by an RN.

D16.5e: Four of five resident files reviewed (one respite) identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident three monthly and records the resident as stable and to be seen three monthly. More frequent examination occurs when a resident health status changes.

Tracer methodology: Rest home resident

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

Tracer methodology: Dementia resident

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Informed consents for storage and collection of information, delivery of care, photograph for ID and display, transport and outings, family involvement in assessment, care plans and evaluation of care plans, resuscitation. Information in discharge summaries, referral letters, medical notes, nursing care discharge summaries and NASC InterRAI assessments received from referring agencies is gathered by the RN to develop the long term care plan within the required timeframes. It is noted that an initial assessment has not been completed by the service for five of five resident files reviewed (three rest home and two dementia). Improvements are required in this area. The RN's have commenced utilising the InterRAI assessment tool – evident in one resident file.

Relatives (one rest home, three dementia) and residents (five rest home) advised on interview that assessments were completed in the privacy of their single room. A range of risk assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to): continence, falls risk, pressure area risk, nutrition, pain and challenging behaviours. Previous audit identified that wound care assessments had not been completed. Wound care documentation for seven residents was reviewed and evidenced that a wound assessment has been completed for each wound. The service has made improvements in this area.

ARC E4.2; Two resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4, 2a Challenging behaviours assessments are completed.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Information in discharge summaries, referral letters, medical notes, nursing care discharge summaries, and needs assessment InterRAI assessments received from referring agencies is gathered by the RN to develop the long term care plan within the required timeframes.

Relatives (one rest home, three dementia) and residents (five rest home) advised on interview that assessments were completed in the privacy of their single room. A range of risk assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to): continence, falls risk, pressure area risk, nutrition, pain and challenging behaviours.

**Finding:**

It is noted that an initial nursing assessment has not been completed for five of five resident files reviewed (three rest home and two dementia).

**Corrective Action:**

Provide evidence that initial assessments are conducted within 24 hours of admission.

**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:**

A long term care plan is developed on admission to guide staff in the safe delivery of care. The registered nurse or clinical coordinator develops the long term care plan from information gathered from admission information, resident and family and risk assessments. The resident long term care plan has categories of care as follows: personal hygiene, elimination, eating and drinking, mobilising, expressing sexuality/spirituality/culture, medication, controlling pain, sleeping patterns/rest, communication, skin/wound care, breathing, memory loss confusion, challenging behaviour, special needs. The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk assessment tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), incident/accident and infection events summary and correspondence.

D16.3k, Short term care plans are available for use to document any changes in health needs. Short term care plans were evidenced utilised for urinary tract infections, changes in health condition, changes to medication, wounds, one pressure area, and behaviours. The service has addressed and monitored this previous finding. It is noted however, on the wound care documentation for seven residents with nine wounds that comprehensive wound treatment plans and frequency of dressings is not recorded in sufficient detail. Improvements are required in this area.

Two of two dementia residents care plans reviewed with challenging behaviours, have behavioural management strategies recorded including triggers and de-escalation techniques. There are 24 hours activities/diversional therapy plans in place for these residents. The service has addressed and monitored this previous finding.

Medical GP notes and allied health professional progress notes are evident in the four of five resident's integrated files sampled (one rest home respite residents). Relatives

(one rest home, three dementia care) interviewed are positive and complimentary about the staff, clinical and medical care provided. They confirm they are kept informed of any significant events and changes in health status.

E4.3 Two resident files reviewed identified current abilities, level of independence and identified needs, with documented behaviour management strategies in care plans including 24 hours diversional therapy plans. There are regular visits from the Nurse Practitioner for mental health of the older person.

### **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 registered nurse or clinical coordinator develops the long term care plan from information gathered from admission information, resident and family and risk assessments. The resident long term care plan has categories of care as follows: personal hygiene, elimination, eating and drinking, mobilising, expressing sexuality/spirituality/culture, medication, controlling pain, sleeping patterns/rest, communication, skin/wound care, breathing, memory loss confusion, challenging behaviour, special needs. The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk assessment tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), incident/accident and infection events summary and correspondence.

D16.3k, Short term care plans are available for use to document any changes in health needs. Short term care plans were evidenced utilised for urinary tract infections, changes in health condition, changes to medication, wounds, one pressure area, and behaviours. The service has addressed and monitored this previous finding.

**Finding:**

It is noted on wound care documentation for seven residents with nine wounds, that comprehensive wound treatment plans and frequency of dressings is not recorded in sufficient detail. Advised by the RN that dressings are usually done on the days that the resident has a shower, however this is not recorded. Nine wound care plans have an assessment completed. The RN records the change of dressing but there is little evidence of a plan of care relating to which dressing products to use and how often the dressing should be changes. The progress of the wound is recorded on wound care documentation and in the computerised progress notes.

**Corrective Action:**

Ensure that each wound care plan records sufficient detail as to the type of care and products to be used and the frequency of the dressing.

**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:**

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for seven residents (link to 1.3.5.2).

The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Residents' care plans are completed by the registered nurse or clinical coordinator (RN). When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The two caregivers interviewed (one from rest home and one from the dementia unit) advised that they have all the equipment referred to in the long term plans necessary to provide care, including hoists, pressure relieving mattresses and cushions, shower chairs, transfer belts, slippery mats, wheelchairs, gloves, aprons and masks.

D18.3 and 4 Dressing supplies are available and a stock of dressing supplies is kept in the clinical coordinators office. All staff report that there are adequate continence supplies and dressing supplies. There are short term care plans in place.

A physiotherapist is involved in manual handling education and resident assessments as required by referral. The podiatrist visits six weekly. The service has access to the community dietitian at Oamaru Hospital and contracted the services of a dietitian to review the menu planner.

### **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:**

A comprehensive social history is complete on or soon after admission and information gathered is included in the care plan. Residents are quick to feedback likes and dislikes to the activity coordinator. Feedback is also received from the resident meeting and satisfaction surveys. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

Caregivers were observed various times through the day diverting residents from behaviours in the King George Wing (dementia unit).

There is one activities coordinator who is completing the diversional therapy training. Activities are provided seven days a week. The programme is planned monthly for the rest home and dementia care unit. The RNs inform the activity coordinator if there are any changes to a resident's physical and cognitive wellbeing that may have an impact on their level of participation in the activity programme. Residents are encouraged to maintain links with community groups such as the RSA, primary schools, kindergarten and church groups. The service has 15-20 volunteers who assist with the activities programme. Volunteers are involved in the home assist with games, puzzles, housie, exercises, walking groups, entertainment and outings. The men's group have enjoyed outings to play mini golf, workshops, the tool shed and the local pub/diner. Visitors to the home include musical entertainers, pet therapy and manicurist. The facility has a hairdressing salon which residents and the local community use. The facility has a van for outings. There are twice weekly outings and inter-home visits, shopping and library visits are enjoyed. Activities in the dementia unit are based on individual abilities and include sensory stimulation and household tasks that include feeding the birds, flower arranging, setting tables, dusting, reminiscing and photo books. There are suggestions of activities on the programme for morning, afternoon and evening times which staff can use when the activities coordinator is not available.

Residents interviewed reported that they get 'out and about' and enjoy the weekly van rides.

Residents in the dementia unit were observed enjoying a visit from an entertainer, newspaper reading, reminiscing, nail care and a combined concert with the rest home residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed during care plan review.

### **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:**

The registered nurse or clinical coordinator completes a care plan evaluation form prior to six monthly care plan review.

D16.4a Six monthly evaluations of the long term care plan are conducted and involve the GP, clinical coordinator or RN, caregivers, activities coordinator, resident/family/whanau input. The resident/family are notified of the review by letter and invited to attend. Previous audit identified that care plan evaluation forms were noted to be incomplete. On review of five files, four of five care plan evaluations have been completed and these have been signed and dated by the RN. The other resident is on respite care. The service has addressed and monitored this previous finding. The long term support plan is amended with each review if there are changes. The family/whanau communication form has written evidence of discussion held with families regarding care plan reviews. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts were evidenced in use.

Short term care plans are utilised and are evidenced to be signed off by a registered nurse on resolution. The service has made improvements in this area.

ARC D16.3c: Long term care plans were evaluated by the RN at six monthly intervals.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals, blister packed medications and collects the returns. Medications are checked and signed by an RN on delivery. Any discrepancies are fed back to the pharmacy. D16.5.e.i.2 Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly (for permanent residents). Nine of ten medication charts were signed. One respite resident's medication chart which has been generated by the pharmacy supplying the medication packs has not been signed by the GP and a short course of medication has been given (now completed) without a medication order. Improvements are required in these areas.

The RN's and senior caregivers undergo a medication competency annually and attend annual education. The medication competency document has been reviewed and now includes a section on competency relating to the management of controlled drugs.

The controlled drug stock is checked weekly. There is a six monthly pharmacy audit. The locked medication trolley for the dementia unit and rest home is kept in the locked clinical coordinators office which is in the dementia unit. The medication fridge is monitored weekly. The RN carries out a weekly check on prn stock. There are no residents self-administering medications. Caregivers are required to contact the RN prior to administering prn medications. The lunchtime medication round observed in the dementia unit met medication safety standards.

Ten resident medication charts (six rest home, four dementia) identified all charts had photo identification and allergies/adverse reactions noted. There is evidence of three monthly GP review of medications. It was noted that in two medication files, there is evidence of transcribing of medication orders. Improvements are required in this area. The medication folder contains information and precautions for specific medications. Staff sign a signing register and the medication signing sheets are all correct. PRN medications have the times given documented and indications for use.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals, blister packed medications and collects the returns. Medications are checked and signed by an RN on delivery. Any discrepancies are fed back to the pharmacy.

D16.5.e.i.2 Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly (for permanent residents). Nine of ten medication charts were signed. Ten resident medication charts (six rest home, four dementia) identified all charts had photo identification and allergies/adverse reactions noted. There is evidence of three monthly GP review of medications. The medication folder contains information and precautions for specific medications. Staff sign a signing register and the medication signing sheets are all correct. PRN medications have the times given documented and indications for use.

**Finding:**

a)One respite resident's medication chart (which has been generated by the pharmacy supplying the medication packs) has not been signed by the GP; b) A short course of medication has been given to the respite resident (now completed) without a medication order; c) It was noted that in two medication files, there is evidence of transcribing of medication orders. The RN has rewritten two medication orders on a piece of paper tucked in front of the medication chart to prompt care staff. These were removed on the day of audit.

**Corrective Action:**

a)Ensure that all medication charts are individually signed by the prescriber; b) Ensure that all medications administered have a corresponding signed order in place; c) Cease the practice of transcribing medication orders.

**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:** FA

**Evidence:****Finding:****Corrective Action:**

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

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

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

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

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D19.2 Staff have been trained in safe food handling. Food services policies and procedures manual is in place. There is a cook on duty each day with an afternoon kitchen hand to serve tea. There is a five weekly summer and

winter menu that is reviewed by a dietitian (December 2013).

All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a notice board and folder of residents likes/dislikes and alternative choices are offered. The cook is informed of dietary changes such as high calorie/high protein diets. Dietary needs are met including normal, soft, pureed, and vegetarian. The main meal is midday lunch. The meals are served from the Bain Marie directly to the residents in the rest home dining room. Meals are transported in the portable bain Marie to a servery hatch in the rest home dining area that opens onto the dementia unit dining room. Meals are plated and served through this servery hatch. The cook's diary is a record of meals served and any menu or resident changes. Food temperatures are taken on the cooked food and on re-heating the tea meal. Fridge, freezer and chiller temperatures are recorded daily. All perishable foods are dated. Nutritional snacks are delivered to the dementia unit including fruit, sandwiches, sweet biscuits, crackers and toppings, muffins and puddings. Caregivers interviewed confirmed they have access to snacks, sandwiches, puddings and beverages in both the rest home and dementia unit. The main kitchen area is equipped with oven/hobs, combisteam oven, fridges and freezers. The dry goods are sealed, labelled and stored off the floor. Goods are rotated weekly with the delivery of food orders. Safety data sheets are available and training provided as required. Chemicals are stored in a locked chemical cupboard. Personal protective equipment is readily available. There is a first aid kit in the kitchen. All equipment is checked regularly and there is a maintenance request book in the nurse's station to log any non-urgent equipment concerns. The cleaning schedule is maintained as sighted. The service receives feedback directly from the residents and from residents meetings. Residents interviewed (five rest home) are happy with the choice and variety of meals.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service displays a current building warrant of fitness which expires on 1 May 2015.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enablers on audit days. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint minimisation policies reviewed February 2013. Staff education on RMSP /Enabler use was conducted in December 2013. Challenging behaviour management and de-escalation techniques training was provided in March 2013. Restraint use and review is part of the monthly management meeting.

E4.4a: The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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### **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:**

Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly management meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the owner/manager. On review of surveillance data and on discussion with RN, there have been no reports of infectious outbreaks. Infection surveillance data is gathered as per standard definitions for infections.

**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.)