Presbyterian Support Central - Cashmere Hospital

Current Status: 15 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

Cashmere and Aotea hospitals are part of the Presbyterian Support Central (PSC) organisation. Aotea hospital provides hospital level care for up to 40 residents and Cashmere hospital provides hospital level care for up to 40 residents. The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator; and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service has addressed all three previous certification audit findings around staff training in cultural safety, care plan interventions and medications.

This audit has identified improvements are required in relation to dissemination of quality data to staff.

Audit Summary as at 15 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

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

Consumer Rights as at 15 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.

Organisational Management as at 15 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 15 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.		Standards applicable to this service fully attained.

Safe and Appropriate Environment as at 15 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.

Restraint Minimisation and Safe Practice as at 15 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 15 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.

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:	Presbyterian Support Central
Certificate name:	Presbyterian Support Central - Cashmere Hospital

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Aotea Hospital; Cashmere Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)
Dates of audit:	**Start date:** 15 October 2014 **End date:** 16 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:	56

Audit Team

Lead Auditor	XXXXXXX	**Hours on site**	14	**Hours off site**	8

Other Auditors		**Total hours on site**		**Total hours off site**	
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXXXX			**Hours**	1.5

Sample Totals

Total audit hours on site	14	Total audit hours off site	9.5	Total audit hours	23.5

Number of residents interviewed	6	Number of staff interviewed	15	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	60	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			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, 20 November 2014

Executive Summary of Audit

General Overview

Cashmere and Aotea hospitals are part of the Presbyterian Support Central (PSC) organisation. Aotea hospital provides hospital level care for up to 40 residents and on the day of the audit there were 21 residents. Cashmere hospital provides hospital level care for up to 40 residents and on the day of the audit there were 35 residents. The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place

The service has addressed all three previous certification audit findings around staff training around cultural safety, care plan interventions and medications.

This audit has identified improvements are required in relation to dissemination of quality data to staff.

Outcome 1.1: Consumer Rights

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

Outcome 1.2: Organisational Management

The quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. PSC Aotea and Cashmere Hospital has a current business and quality plan to support quality and risk management at each facility. PSC Aotea and Cashmere Hospital collates data for comparisons against other PSC homes and with an external benchmarking company. Meeting minutes are completed; all internal audits are conducted as per the audit programme and collation of quality information including incident and accident reports are conducted in timely manner. An improvement is required round dissemination of quality data to staff. Resident/relative surveys are undertaken annually. Incidents and accidents are appropriately managed with clinical follow up and investigations conducted. There is a two yearly in-service training programme with compulsory training days that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

Outcome 1.3: Continuum of Service Delivery

Registered nurses are responsible for each stage of service provision. A care plan is developed in consultation with the resident and family/whanau where appropriate. Service delivery plans are individualised, up-to-date and reflect current service delivery requirements for each resident. The plans are reviewed at least three monthly. Short term support plans are utilised for changes in health status such as infections, weight loss and wounds. General practitioners conduct three monthly clinical reviews. Residents interviewed are complimentary about the care provided. Activities are provided that reflect ordinary patterns of life and encourage residents to remain integrated in their community. There are comprehensive medication management policies and procedures in place. Medications are appropriately managed and administered by staff that have completed annual medication competencies. Residents have a nutritional assessment completed on admission and dietary requirements and likes and dislikes are recorded. Special diets are catered for to meet residents' needs and specialist input is accessed as required.

Outcome 1.4: Safe and Appropriate Environment

The facility displays a current building warrant of fitness at both sites.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes definitions of restraint and enablers. There are 16 residents assessed as requiring an enabler, and no residents using restraint. Staff are trained in restraint minimisation and managing challenging behaviours.

Outcome 3: Infection Prevention and Control

The infection control nurse at PSC Aotea and Cashmere Hospital completes a monthly infection summary which is discussed at clinical and management meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	0	0	0
Criteria	0	37	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	63

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is no evidence in the staff meeting minutes and registered nurse meeting minutes that quality data relating to accidents/incidents an infections is discussed with staff.	Ensure that quality data relating to incidents/accidents and infections is documented in the meetings minutes for full staff meetings and registered nurse meetings.	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 1.1.4: 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:

The previous audit identified that staff had not had training around meeting the needs of Maori residents (1.1.4.2). Cultural/treaty training has been provided on 29 May 2013 (28 staff attended), July 2014 (22 Staff attended) and Maori cultural care August 2014 (17 staff attended). This was a previous audit finding that has now been addressed.

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

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

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

Attainment and Risk: FA

Evidence:

The service has an open disclosure policy stating residents and /or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Six residents (one from Aotea and five from Cashmere) and five family members (two from Aotea and three from Cashmere) stated they were welcomed on entry and were given appropriate time and explanation about services and procedures. Resident/relative meetings occur six monthly (June 2014 and planned for October 2014). Advised by the manager, care manager, two clinical coordinators and two registered nurses that they have an open-door policy. Interpreter services are accessible via the local DHB.

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 Five family members stated that they are always informed when their family members health status changes.

D11.3 The information pack is available in large print and advised that 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 1.1.13: 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 are available in the reception area waiting room in both facilities. An electronic complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. An electronic complaints folder is maintained and all individual complaints (written and verbal) are documented or scanned on to the computer. There has been one written complaint for (Aotea) and four written complaints (Cashmere) in 2014. All complaints reviewed

evidenced appropriate documentation and management. All complaints have been resolved. The electronic complaints folders and register is kept up to date with evidence of follow up and resolution. There is evidence of advocacy support for complainants. Five health care assistants (two from Aotea and three from Cashmere), two clinical coordinators, two registered nurses, one quality coordinator, one care manager and one manager confirm that all complaints are reported and recorded. Complaints are reported and discussed at senior team management meetings and to the organisation.

Resident and family satisfaction survey was conducted in September 2013 with residents and families advising that they were more than satisfied with the care and services they receive. The satisfaction survey for September 2014 is still to be collated.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Cashmere and Aotea hospitals are part of the Presbyterian Support Central organisation. Aotea provides hospital level care for up to 40 residents and on the day of the audit there were 21 residents. Cashmere provides hospital level care for up to 40 residents and on the day of the audit there were 35 residents. The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.

Cashmere and Aotea hospitals have a documented mission statement, vision, values, corporate commitment and older person's services goals.

There is a local risk management plan for 2014. There is an Enliven (Cashmere and Aotea) business plan that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals.

The service has a robust structure that supports the continuity of management and quality of care and support (including staff management).

The manager is a registered nurse with over 40 years' experience with over 20 years' experience managing in the retirement industry. She has been in the position for two and a half years.

PSC provides care manager orientation training and support at least every two months across the organisation. The service has employed a care manager since the last certification audit with 10 years nursing experience and is currently completing a masters degree in nursing. She has attended InterRAI training, 4 quadrant leadership training and attended the core clinical days provided by the organisation.

The organisation also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least 8 hours annual professional development activities related to overseeing clinical care.

ARC D17.4b (hospital) The manager has maintained at least eight hours annually of professional development activities related to managing a hospital. Since her employment the manager has completed a three day Eden training course, the four quadrant leadership training and is attending the aged care conference October 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a current business, quality and risk management plan for 2013 - 2014. The quality plan includes goals relating to a quality improvement system, respecting the individual values and beliefs and rights of residents, operating in a safe environment for residents and staff, and to provide effective clinical care. The plan includes corporate commitment and service goals which have expected measures and results achieved in progressing towards the goals. The plan is reviewed three monthly with a report sighted for the July 2013 – June 2014 period. The service is to be externally audited in November 2014 for final implementation of the Ten Eden Principles and hopes to be the first PSC hospital to complete the Eden Principles. The service has continued implementing their quality and risk management system since previous certification. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that is being implemented at Aotea and Cashmere Hospital. There is a designated quality coordinator who has been in the role four years and was previously employed at the service as a registered nurse for ten years. The manager provides a monthly report to central office. PSC Aotea and Cashmere Hospital has a senior management team that includes key staff from all areas of the service and a clinical team. The senior management team meeting includes areas for health and safety, infection control, clinical, chaplain, recreation, education, restraint and projects update. Staff interviewed were able to discuss the quality systems and Eden philosophy / approach.

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. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's ongoing progress around quality improvement. PSC has reviewed the quality structure of its service to include quality reporting within all areas. There is an internal audit schedule, meetings calendar and education plan for 2014. All audits have been completed according to the schedule. Combined staff meetings are held each month alternating at each site (last meeting held 24 September 2014). Discussion occurs around health and safety, equipment, and management and clinical reports are presented from their respective meetings. There is a senior management/clinical team meeting held two weekly with discussion on occupancy, reports from each site, resident status, corrective actions from internal audits, infections, clinical review and policies for review (minutes viewed 18 September 2014). At this meeting discussion was held regarding the services of a person that could speak Russian to assist with communication of a resident that is non-English speaking.

There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule. Policies and procedures cross-reference other policies and appropriate standards. New policies are circulated to staff and staff sign that they have read the new /updated policies. Pain policy has recently been updated (August2014).

D5.4: The service has policies/ procedures to support service delivery.

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.

There is a comprehensive infection control manual as well restraint policy and health and safety policy/procedures.

Monthly accident/incident reports are completed by the registered nurses, clinical coordinators and care manager with collation of data and entry on to an electronic spread sheet conducted by the quality coordinator. These are also compared with last month. The monthly graph reports are provided to staff via staff notice boards however there is no evidence of documentation in the staff meeting minutes and the registered nurse meeting minutes that this data is discussed. This is an area requiring improvement. External benchmarking indicator results (that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents) has been conducted and all data has been collated.

Health and safety monthly report is completed and presented to the senior management team meeting. The report includes identification of hazards and Incidents and accidents reporting and trends identified.

The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. Results are sent to PSC approval group for analysis. The restraint coordinator completes a monthly report which is tabled at the quality committee.

Internal audits conducted in 2014 include activities, restraint, fire drill, food services, laundry, nutrition, pressure area, pain, personnel files, complaints, incidents, and education. The range of meetings include: staff, senior management team, residents, health and safety, registered nurses and Eden Associates. These meetings and quality reports provide the means to measure achievement of the implemented quality and risk system. Quality improvement processes are in place to capture and manage non-compliances, internal audits and corrective actions. The quality coordinator monitors corrective actions. The service establishes corrective actions in response to data and other inputs. Corrective actions identify responsibilities and timeframes for completion. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Corrective actions 2014 have included pain assessments, nutrition management and pressure are management all with 100% compliance following corrective actions. A hazard register is established that includes a hazard register for all areas of the facility. There is also an implemented hazard monitoring form that is implemented for environmental inspections. Currently Aotea is completing renovations to upgrade some of the bedrooms. All hazards associated with the renovations are entered on the hazard register and all signs are placed appropriately to advise staff, visitors and residents.

There is documented evidence that the service quality goals are discussed and progress to meeting the goals are reviewed at the senior management team meeting and clinical team meeting. A resident/relative survey was conducted in September 2013 via an external organisation with overall satisfaction reported on the care and services provided by the service.

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

D19.2g Fall prevention strategies such as environmental hazards review, mobility and transferring assessment, foot wear review, falls risk assessments.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

A clinical management team meeting is held every two weeks and discussion occurs around infections, resident clinical issues, quality issues, and policies for review. The range of meetings include: staff, senior management team, residents, health and safety, registered nurses and Eden Associates. These meetings and quality reports provide the means to measure achievement of the implemented quality and risk system. Monthly accident/incident reports are completed by the registered nurses, clinical coordinators and care manager with collation of data and entry on to an electronic spread sheet, conducted by the quality coordinator. These are also compared with the previous months. The monthly reports are provided to staff via meetings and staff notice boards. External benchmarking indicator results (that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents) has been conducted.

Finding:

There is no evidence in the staff meeting minutes and registered nurse meeting minutes that quality data relating to accidents/incidents an infections is discussed with staff.

Corrective Action:

Ensure that quality data relating to incidents/accidents and infections is documented in the meetings minutes for full staff meetings and registered nurse meetings.

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:

The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is entered on to a spread sheet for collation and analysis the external benchmarking service is utilised other than for resident/relative survey. Incident/accidents are documented; reporting of incidents occurs and is monitored with action taken on trends to improve service delivery. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service documents family contact following an incident. A sample of 10 incident reports (five from Aotea and five from Cashmere) for September 2014 were reviewed (relating to skin tears, falls, bruising), all were completed and documented that family were notified as per instructions. There was evidence in progress notes that family/next of kin have been contacted. Clinical follow up is conducted by a registered nurse with further investigations conducted by the clinical coordinators, care manager and/or manager. Incident reporting audit was conducted in June 2014 with 86% compliance achieved. A corrective action plan has been completed in relation to fully completing documentation on incidents form with a re-audit achieving 100%.

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:

Aotea and Cashmere Hospital PSC employ 60 permanent full time and part time staff over both sites. 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 or collective agreement letters of employment were sighted in six of six staff files reviewed. There are job descriptions available for all positions and staff advised that they have employment contracts. Six staff files (two from Aotea and four from Cashmere) were reviewed and included one registered nurse, five health care assistant's, one clinical coordinator and one care manager. The manager conducts annual staff appraisals and all six files evidence annual appraises completed. The manager is responsible for recruitment of staff. On review of one recently employed registered nurses file, there is evidence of documented reference checking. A copy of qualifications and annual practising certificates including registered nurses and general practitioners is kept and these were sighted for all GP's, pharmacists, dietitian, podiatrist and all 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. Health care assistants (five) and registered nurses (two) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One recently employed staff member had completed the orientation programme.

There is a staff training policy and a staff performance monitoring policy. Discussion with the registered nurses and health care assistants confirm that the service provides in-service training and education that covers relevant aspects of care and support and meets requirements. The education programme includes compulsory training days for health care assistants and registered nurses which are run each month. The programme alternates each year with year one (2013): restraint and challenging behaviour, abuse and neglect, fire safety, hazards and security, infection control and hand washing, cultural and spiritual safety, residents rights and advocacy and year two (2014): fire and evacuation, ageing process, intimacy and sexuality, communication and Eden philosophy, infection control and hand washing, restraint and challenging behaviour, safe food handling, wounds and medication. Manual handling and first aid are also compulsory.

The annual training programme exceeds five hours annually. Health care assistants interviewed (five) advised that they have either completed the ACE programme or an equivalent qualification. The service provides career force training for health care assistants.

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 both hospital sites. The service runs as two separate facilities and some staff work over both sites. Minimum staffing levels over night include one registered nurse on duty and one health care assistant in both facilities. There is at least one registered nurse on duty at all times at each facility. Each facility has a mixture of health care assistants working short and long shifts. On morning shift at Aotea there are five health care assistants and on the afternoon shift there are four health care assistants. At Cashmere on the morning shift there are eight health care assistants and on the afternoon shift there are five health care assistants. During week days there is a care manager who oversees both facilities and a clinical coordinator (one at each facility). The clinical coordinator at Aotea has completed a masters degree in health care in 2013. The manager provides managerial oversight for both facilities. There are designated staff for kitchen, laundry, cleaning and activities. Residents interviewed (six - one from Aotea and five from Cashmere) and five family members (two from Aotea and three from Cashmere), advised that there is sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to resident's needs.

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.)*

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:

The registered nurses at PSC Aotea and Cashmere Hospital are responsible for development of the care plan with input from the health care assistants. The initial support plan is developed within 24 hours of admission. The assessment and support planning policy describes; guidelines for resident assessment, initial support plan, resident support plan, short-term care plan, evaluation, medical reviews, and interdisciplinary reviews. Evaluations and reviews are completed by the registered nurse. Continuing assessments are completed within one week of admission and the long term support plan is developed within three weeks. Assessments include pressure area risk, falls risk, nutrition, pain, behaviour, mobility, continence and social and medical history. InterRAI assessments are being implemented. Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the support plan. Communication with family is documented. A verbal handover occurs at the end of each shift which includes and encourages input from all staff including the Chaplain (as observed on the day of the audit). Reflective training also occurs at handovers. There is also a communication book. Staff are informed of any support plans that have been updated at handover.

Five health care assistants interviewed (who work across all shifts and both sites) describe a verbal handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes are written at the end of each shift. Registered nurses document on a health summary sheet where there are any health issues or changes. Any issues arising from quality meetings and resident meetings are communicated to staff (# link 1.2.3.6). The registered nurses inform staff of any changes to residents' care following visits from the general practitioner or other allied healthcare personnel and also documents this information in residents' progress notes and support plans. Five of five resident files (two from Aotea and three from Cashmere) identify integration of allied health personnel and a team approach is evident.

Input from a number of allied health personnel is evident in all five files reviewed including physiotherapist, activity staff, podiatrist and dietitian.

Communication with family is documented in the progress notes. Five family members stated they were involved in assessment, care planning and review of the support plans.

D16.2, 3, and 4: Five of five files reviewed identified that an assessment was completed within 24 hours by a registered nurse.

D16.5e: Five resident files reviewed identified that the general practitioner had seen the resident within two working days of admission with three monthly (and as needed) reviews. Three monthly medication reviews by a general practitioner is documented in the medical notes section of all five residents files reviewed. A care plan is developed within three weeks of admission and is signed and dated by the registered nurse. The GP interviewed advised that the staff are prompt to notify him of changes in health status of residents and that they provide excellent resident centred care.

Tracer Methodology.

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 1.3.6: 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:

All five support plans viewed (two from Aotea and three from Cashmere) are completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with the GP, five health care assistants, two registered nurses, two clinical coordinators, one care manager, one manager, six residents (one from Aotea and five from Cashmere) and five family members (two from Aotea and three from Cashmere). Support plans include the following sections: hygiene and grooming, mobility, nutrition/fluids, skin and pressure area care, elimination, emotional wellbeing, loneliness, helplessness, rest and sleep, communication, spirituality, faith and culture, and medical. Short-term support plans are used for acute or short-term changes in health status.

Resident's needs are assessed prior to admission and have the services of the house Doctor - or their own GP if they prefer. There is evidence of referrals to specialist services such as community psychiatric nurse, dietitian, physiotherapist, podiatry. The service could describe links with other services such as the hospice, needs assessment and other services working with residents.

There is a care manager for 40 hours per week and a clinical coordinator based at each facility and registered nurse cover 24 hours a day. Policies and procedures and internal audits are reviewed. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by the registered nurse. Support plans are goal oriented and reviewed at least three monthly for all residents. Residents support plans are updated with changes in health status as evidence in all five support plans reviewed. The service has addressed previous audit findings around care plan interventions. When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The five health care assistants, two registered nurses and two clinical coordinators interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, sit on weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies.

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. There is a programme of activities in place and residents are able to access the community and associated services and support. There is a resident care manual.

All five files reviewed contained a continence assessment and interventions were documented in the resident's support plans. Specialist continence advice is available as needed and this could be described by staff. 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.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence management in-services and wound management in-service have been provided as part of the compulsory training days for health care assistants and registered nurses in 2014.

Wound assessment and wound management plans are in place for five residents at Aotea and for 13 residents at Cashmere with wounds. Documented wounds include skin tears, abrasions, lesions and venous ulcers. The wound specialist has involvement with three pressure areas and two other wounds. Short term support plans are used initially for all wounds. Wounds still being treated after three weeks are required to be transferred to a chronic/complex wound treatment plan. Short term support plans are in place for 12 recently developed wounds (four at Aotea and eight at Cashmere).

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There are two recreation officers (one based in each hospital) and a group of volunteers (20) that deliver the seven day per week recreational programme. The recreational officers provide activities in the lounges, gardens (weather permitting) dining areas and also provides one on one input in residents rooms when required. On the two days of audit residents in both areas were observed being actively involved with a variety of activities. Activities are planned that are appropriate to the capabilities of residents and

meet with the Eden philosophy and principles. Each area has its own programme and there is interaction between the facilities. Recreation officers are rostered to cover the weekends for 9am-12pm. On admission the recreation officer completes an activity social profile documenting resident's social history, likes and dislikes and past and present interests. The individual recreation plan is completed within three weeks. Residents are able to participate in an exercise programme, quizzes, beauty therapy, one to one activities, outings, church services, visiting entertainment, movie nights, gardening, bowls, reminiscing, crafts, music and a variety of activities to maintain strength and interests. Participation in activities is voluntary. Daily attendance records for each resident is kept. The five resident files reviewed also includes how the resident likes to spend their day. The resident/family/whanau as appropriate is involved in the development of the recreation plan. There is a wide range of activities offered that reflect the resident needs and interests. Participation in all activities is voluntary. One on one activity occurs with residents and the recreational officers and volunteers ensure that all residents have some one on one time each month. The service has volunteers to assist with activities. The programme is developed monthly and displayed in large print. Residents have a copy of the programme displayed on the wall in their rooms. Recreation officers have attended a variety of education through PSC peer support annually and through the recreation interest group that meets monthly. The recreation team leader has also attended "Spark of life" education seminars and education on the Eden Principles. The programme includes networking within the community with social clubs, churches and schools. Residents are able to provide feedback and suggestions for activities at the resident meetings which are held quarterly (June 2014 and planned for October 2014). Results of resident satisfaction survey completed in September 2013 record positive outcomes.

As part of the Eden philosophy the recreational officers meet with the residents monthly informally and the residents help to plan the activities programme to allow ownership of the programme by the residents. During lunch one of the residents announces the afternoon programme to the other residents. Residents are involved with the community by growing native trees and plants which are then taken and planted in local reserves.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. Residents report they are satisfied with the activity programme offered to them by the facility.

The facility has two vans (one of which allows for wheelchair access) and two outings occur weekly. The recreational officers hold a current first aid certificate. Residents report they are very satisfied with the recreation programme offered to them by the facility and residents report they can attend local churches and participate in activities of choice.

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 support plans were developed by a registered nurse on day of admission and resident support plans developed within three weeks of admission. Support plans are evaluated on a three monthly basis or if there is a change in health status by the registered nurse with input from the health care assistants and family. A review of five support plans evidenced all five support plans show documented evidence of three monthly evaluations. There is a general practitioner (as described on interview) review every three months and on an as required basis. The 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.

Short term support plans are in use for changes in health status and are recorded on a problem page. Examples sighted are for wounds, continence, infections and weight loss.

D16.4a Support plans are evaluated three monthly for all residents or more frequently when clinically indicated.

D16.3c: All initial support plans are evaluated by a registered nurse within three weeks of admission. The long term care plan is developed within three weeks of admission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service uses four weekly blister packs for the administration of medications at PSC Aotea and Cashmere Hospital. Ten medication charts were reviewed (four from Aotea and six from Cashmere) and all medication charts have photo identification.

There is a signed agreement with the pharmacy. Blister pack medications are checked on arrival by two registered nurses, a verification form is completed and signed and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication trolleys and medications are stored in a treatment room at both sites. There is one treatment room on each site. There is one medication trolley at each site. Controlled medications are stored in the treatment room at both sites in a locked safe.

There are no standing orders. Staff sign for the administration of medications on medication sheets held with the medicines. There are copies of staff signatures at the fount of each medication folder. The manager holds a list of specimen signatures and competencies

Each site has a register for controlled drugs. Controlled drugs are checked by the Pharmacist and two registered nurses on arrival and these are checked weekly as per records reviewed and sighted.

The registered nurses are responsible for administration of all medications. Medication competencies are completed annually for all staff administrating medications. Medication competencies include insulin, controlled drugs, syringe driver (for registered nurses) and pain. Medication audit has been completed April 2014. Medication errors are identified and the facility has developed a process for staff management of medication errors which outlines all types of medication errors and corrective action to be taken. The facility has a policy on self-administration of medications which includes a three monthly competency review for residents. There are currently no residents self-administering medications at PSC Aotea or Cashmere Hospital. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Charts are easy to read and current. Staff monitor the medication fridge in both treatment rooms weekly (sighted). Medication management education last provided in 2014 as part of the compulsory training days for health care assistants and registered nurses. Three registered nurses were observed safely administrating medications (one at Aotea and two at Cashmere). Eye drops on both trolleys were dated on opening. The service has addressed a previous audit finding around medication signing sheets.

D16.5.e.i.2; Ten 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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a workable kitchen that is well equipped and maintained. There is a preparation area and receiving area. The service has two cooks, one relieving cook and kitchen assistants. The main cook is currently completing a level three and four hospitality course through service IQ. The kitchen at Cashmere Hospital also prepares and cooks meals for Aotea hospital. Food is prepared and cooked and transferred in insulated containers to Aotea hospital. Food temperatures are recorded prior to leaving Cashmere hospital and prior to serving in Aotea hospital. Fridge and freezer temperatures are monitored daily. Food temperatures are also recorded in Cashmere hospital. All food was covered and stored on shelving above floor level. There is a food services manual that ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. A tour of the kitchen noted cleanliness and order in the pantry and fridges complying with guidelines. Food safety update was provided for all staff in 2014.

All fridges and freezer temperatures are recorded daily on the recording sheet which was sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily. Dry food stuffs are stored in a storage area in the kitchen. All food was covered and stored on shelving above floor level.

A nutritional profile for each resident is completed on admission and updated at care plan review. There is a likes and dislikes folder maintained in the kitchen for individual resident preferences. There is an external provider dietitian available for individual resident need. The menu is designed and reviewed by a PSC registered dietitian in September 2014. The six weekly menu is varied with evidence of review. Cashmere and Aotea are multicultural facilities with residents who have specific nutritional needs

related to their culture or beliefs. Special diets are catered for including Halal, Indian, diabetic, vegetarian and high protein diets. Staff were observed to assist residents with their meals and drinks and the service has modified plates and cutlery. Residents are weighed monthly or more frequently if required. Six residents interviewed were very complimentary about the food provided and like the variety of the menu. Resident satisfaction survey which includes food was completed in September 2013 and showed overall satisfaction with the food service. Kitchen staff meetings are held as required. There is a two monthly conference call at an organisational level for all cooks/chefs to discuss the menu and other food service matters.

D19.2: Staff have been trained in safe food handling. Six residents interviewed were complimentary of the food service and enjoy the variety of the menu.

Staff interviewed were aware of resident's likes and dislikes and those with special dietary needs including cultural needs.

Five family members interviewed stated they have visited at meal times and the food has been well presented.

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.)*

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:

There is a restraint minimisation and safe practice policy is applicable to the service. The policy states that “restraint is the intentional restriction of a person’s voluntary movement or behaviour by the use of a device, medication, physical hold or force for the purpose of controlling the residents escalating or unusual behaviour (challenging behaviour or wandering). The policy states that ‘enabler is the term applied to equipment such as bedrails, noodles, bed wedges, lap/thigh belts, used to promote the independence, comfort and safety of the resident. The service does not have any residents on restraint according to the policy. The policy includes an enabler protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. Enabler assessment tools are completed for residents requiring bedside rails, lap belts, chair harness and thigh belts. The policy includes comprehensive enabler procedures. The process of assessment and evaluation of enabler use is included in the policy. There are five residents at Aotea with five enablers in use and 11 residents at cashmere hospital residents with 13 enablers in use. Enablers include 11 bedrails, one thigh belt and one support chair harness. On review of five residents (one from Aotea and four from Cashmere) with enablers, there is evidence of assessment, consent obtained and three monthly evaluation. Enabler monitoring is documented in the care plans and in

the progress notes as evidenced in all five files reviewed. All five files reviewed show evidenced of documented risks associated with enabler use. Staff have received education on restraint minimisation and challenging behaviour management in 2014 as part of the compulsory training days for health care assistants and registered nurses. On interview five health care assistants were knowledgeable about restraint minimisation and alternatives and in managing challenging behaviours.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The infection control (IC) surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC co-coordinator (rest home senior registered nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and the laboratory that advises and provides feedback /information to the service. Infections are reported via standard definitions, and are then recorded on an individual infection reporting form. Short term support plans have been developed for use with residents with infections and a flow chart for management of infections has been developed.

The service utilises an external benchmarking programme which analyses service data on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility. Infection control data is collated monthly and reported to the monthly clinical management meeting. The meetings include the monthly IC report and benchmarking quarterly results as available. All infections are documented on the infection monthly register and forwarded to a central register for PSC. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. An infection control audit which included hand hygiene was completed in September 2014 with 100% compliance. Results of surveillance and audits are communicated to staff via management meetings, clinical meetings (l# link 1.2.3.6), staff meetings, at handover time and via information and graphs posted in the staff room. The service managed to contain one resident with scabies who was seen by a skin specialist in January 2014. There have been no outbreaks at the service over 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.)*