

Thornton Park Retirement Lodge Limited

Current Status: 13 November 2012

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

General overview

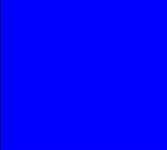
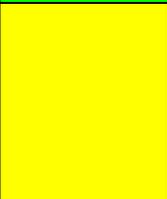
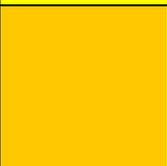
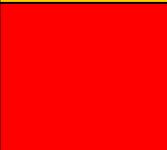
Thornton Park Retirement Lodge is certified to provide hospital and rest home level care for up to 42 residents. On the day of the audit, there were 17 residents in the hospital and 17 residents in the rest home. The manager is a registered nurse who has been employed by the service in a managerial role for four years.

There are improvements required around resident/family/whanau involvement in care planning, pain assessments, short term care plans for short-term needs, assessment and monitoring of self-medicating residents, and defining the role and responsibilities for the restraint coordinator and the infection control coordinator.

Audit Summary as at 13 November 2012

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 13 November 2012

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 13 November 2012

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 13 November 2012

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 13 November 2012

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 13 November 2012

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 13 November 2012

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.
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Audit Results as at 13 November 2012

Consumer Rights

The Code of Health and Disability Rights (the Code) is incorporated into the residents' cares. Residents and families confirm that their rights are being upheld. Information about the Code is

readily available to residents and families. Interviews with staff confirm their understanding of the Code. Staff were able to provide examples of how they incorporate the Code into their work practice.

Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. There are currently 13 residents who identify as Maori living at the facility.

Residents and their families are aware of how to make a complaints and their right to do so. The complaints process ensures issues are managed in a timely manner.

Organisational Management

Services provided to the residents are planned, coordinated and are appropriate to meet the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements.

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

Continuum of Service Delivery

Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The nurse manager and registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to develop and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified in the long-term care plans and these are reviewed within the required timeframes.

Residents' files include notes by the GP and allied health professionals. There are improvements required around resident/family/whanau involvement in care planning, pain assessments and short-term care plans for short-term needs.

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. There is an improvement required around the assessment and monitoring of self-medicating residents.

The activities programme is facilitated by a diversional therapist and diversional therapy assistant for the hospital and rest home. The activities programme provides varied options and activities that are enjoyed by the residents. Activities meet the individual spiritual, cultural, physical and

emotional needs of the residents. The community including various Churches visit the premises and community outings are arranged on a regular basis.

Food is prepared and cooked on site. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented and residents and relatives are happy with the food service

Safe and Appropriate Environment

Residents are provided with safe, adequate, age appropriate facilities. There is a scheduled and reactive maintenance process and a long term maintenance programme in place. Safe and hygienic cleaning and laundry services are provided for residents and the facility is clean, neat and tidy. The home has adequate heating and ventilation throughout. There is a dedicated outdoor smoking area which does not expose non-smokers to tobacco smoke.

Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. During this audit five residents were using an enabler and three residents were using a restraint. The restraint assessment process ensures restraint is used as a last resort. Any restraint or enabler use is recorded in an auditable format.

Staff are required to attend restraint minimisation and safe practice education and training.

A system of evaluation and review of any restraints used by residents is in place. The service also regularly reviews the restraint minimisation programme.

Infection Prevention and Control

The infection prevention and control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control coordinator is the nurse manager who is responsible for coordinating/providing education and training for staff. The infection coordinator has attended external training.

Infection prevention and control training is provided at orientation and is on-going. The coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. There is an improvement required around defining the role and responsibilities for the infection control coordinator.

HealthCERT Aged Residential Care Audit Report (version 3.9)

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:	Thornton Park Retirement Lodge Limited
Certificate name:	Thornton Park Retirement Lodge
Designated Auditing Agency:	HDANZ
Types of audit:	Certification audit
Premises audited:	Thornton Park Retirement Lodge, 138 State Highway 35, Opotiki
Services audited:	Rest Home and Hospital level care
Dates of audit:	Start date: 13 November 2012 End date: 14 November 2013
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	

Audit Team

Lead Auditor	XXXXX	Hours on site	14	Hours off site	8
Other Auditors	XXXXX	Total hours on site	7.5	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	3

Sample Totals

Total audit hours on site	22	Total audit hours off site	17	Total audit hours	39
Number of residents interviewed	6	Number of staff interviewed	12	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	33	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Thursday, 19 December 2013

Executive Summary of Audit

General Overview

Thornton Park Retirement Lodge is certified to provide hospital and rest home level care for up to 42 residents. On the day of the audit, there were 17 residents in the hospital and 17 residents in the rest home. The manager is a registered nurse who has been employed by the service in a managerial role for four years.

There are improvements required around resident/family/whanau involvement in care planning, pain assessments, short term care plans for short-term needs, assessment and monitoring of self-medicating residents, and defining the role and responsibilities for the restraint coordinator and the infection control coordinator.

Outcome 1.1: Consumer Rights

The Code of Health and Disability Rights (the Code) is incorporated into the residents' cares. Residents and families confirm that their rights are being upheld. Information about the Code is readily available to residents and families. Interviews with staff confirm their understanding of the Code. Staff were able to provide examples of how they incorporate the Code into their work practice.

Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. There are currently 13 residents who identify as Maori living at the facility.

Residents and their families are aware of how to make a complaints and their right to do so. The complaints process ensures issues are managed in a timely manner.

Outcome 1.2: Organisational Management

Services provided to the residents are planned, coordinated and are appropriate to meet the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements.

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

Outcome 1.3: Continuum of Service Delivery

Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. The nurse manager and registered nurses are responsible for each stage of service provision.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to develop and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified in the long-term care plans and these are reviewed within the required timeframes.

Residents' files include notes by the GP and allied health professionals. There are improvements required around resident/family/whanau involvement in care planning, pain assessments and short-term care plans for short-term needs.

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. There is an improvement required around the assessment and monitoring of self-medicating residents.

The activities programme is facilitated by a diversional therapist and diversional therapy assistant for the hospital and rest home. The activities programme provides varied options and activities that are enjoyed by the residents. Activities meet the individual spiritual, cultural, physical and emotional needs of the residents. The community including various Churches visit the premises and community outings are arranged on a regular basis.

Food is prepared and cooked on site. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented and residents and relatives are happy with the food service

Outcome 1.4: Safe and Appropriate Environment

Residents are provided with safe, adequate, age appropriate facilities. There is a scheduled and reactive maintenance process and a long term maintenance programme in place. Safe and hygienic cleaning and laundry services are provided for residents and the facility is clean, neat and tidy. The home has adequate heating and ventilation throughout. There is a dedicated outdoor smoking area which does not expose non-smokers to tobacco smoke.

Outcome 2: Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. During this audit five residents were using an enabler and three residents were using a restraint. The restraint assessment process ensures restraint is used as a last resort. Any restraint or enabler use is recorded in an auditable format.

Staff are required to attend restraint minimisation and safe practice education and training.

A system of evaluation and review of any restraints used by residents is in place. The service also regularly reviews the restraint minimisation programme.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control coordinator is the nurse manager who is responsible for coordinating/providing education and training for staff. The infection coordinator has attended external training.

Infection prevention and control training is provided at orientation and is on-going. The coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. There is an improvement required around defining the role and responsibilities for the infection control coordinator.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	45	0	5	0	0	0
Criteria	0	96	0	5	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	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	The six care plans viewed did not provide written evidence that the resident or family/whanau are involved in the care planning process	Ensure there is written evidence of resident/family/whanau participation in the care planning process	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	i) There are no pain assessments in place for two residents Eg: rest home resident with frequent falls and prescribed prn pain relief as per the long-term care plan and one hospital resident with dementia who is on regular and prn pain relief as identified in the long-term care plan. ii) There is no short-term care plan in place for a rest home resident on return from hospital with medical and medication changes.	i) Ensure pain assessments are completed for all residents who identify pain and are on regular or prn pain relief. ii) Ensure short-term care plans are in place for residents with short-term needs or changes to health needs.	60
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 Low			
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	The resident has not had a self-medication competency assessment completed. There is no evidence of self-medication monitoring in place.	Ensure self-medication competency is completed and monitoring of self-medication administration occurs.	60
HDS(RMSP)S.2008	Standard 2.2.1: Restraint approval and processes	Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(RMSP)S.2008	Criterion 2.2.1.1	The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.	PA Low	Responsibility for restraint coordination is delegated to a registered nurse but this responsibility has not been clearly defined.	Ensure the restraint coordinator's role and responsibilities are clearly defined.	180
HDS(IPC)S.2008	Standard 3.1: Infection control management	There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low			
HDS(IPC)S.2008	Criterion 3.1.1	The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.	PA Low	The responsibilities for the infection control coordinator are not clearly defined.	Ensure the responsibilities for infection control is clearly defined	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

The Code of Health and Disability Rights (the Code) is incorporated into care. Discussions with four caregivers who work in both the rest home and the hospital and one registered nurse verified their familiarity with the Code. A review of six care plans, monthly staff meeting minutes and discussions with six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) confirms that the service functions in a way that complies with the Code. Observations during the audit confirmed this in practice.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The service provides information about the Code to residents. If necessary, staff will read and explain information to residents. Information is also given to next of kin or their enduring power of attorney (EPOA) to read to and/or discuss with the resident in private. On entry to the service, a registered nurse discusses the information pack with the resident and their family/whanau. This includes the code of rights, complaints and advocacy information. Discussions with all six residents interviewed (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) identified they are well informed about the Code. The service provides an open-door policy for concerns or complaints. All 12 respondents in the Sept 2013 resident satisfaction survey felt that their rights were respected.

Clients' right to access advocacy services is identified for residents and family in Health and Disability Advocacy Service leaflets that are available at the entrance to the facility. This information identifies whom the resident can contact to access advocacy services. Discussions with four caregivers who work in both the rest home and the hospital and a registered nurse identified they are aware of the residents' right to advocacy services and how to access and provide advocacy information to residents if needed.

D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health and Disability Commissioner information.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a privacy policy. Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information.
Discussions with six of six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) identified that personal belongings are not used as communal property.
During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews residents and family identified that caregivers always respect residents' privacy. Resident files are held in a locked cupboard.

Residents' support needs are assessed using a holistic approach. Initial and on-going assessment includes gaining details of the resident's beliefs and values. Intervention to support these beliefs and values are identified and evaluated.
All six residents interviewed (three from the hospital and three from the rest home) and three family members interviewed (two from the hospital and one from the rest home) confirmed that the service is respectful and responsive to the residents' needs, values and beliefs.
Resident/relative satisfaction surveys are carried out annually to gain feedback. In the survey completed in Sept. 2013, all respondents were satisfied that their cultural and spiritual needs are being met.

Each resident is treated in a personal way to assist them to meet their individual living requirements. This is evident through observation and discussions with four caregivers who work in both the rest home and the hospital, a registered nurse, all six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home).

The information pack provided to residents and their families includes the home's philosophy of care. Discussions with all four caregivers who work in both the rest home and the hospital, a registered nurse, all six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) confirm that residents are provided with choices and are able, within the constraints of the service, to exercise freedom of will.

There is an abuse and neglect policy. Staff can describe definitions. Discussions with all four caregivers who work in both the rest home and the hospital and a registered nurse identifies that there is a strong culture of reporting. Six of six residents interviewed (three from the hospital and three from the rest home) and three family members interviewed (two from the hospital and one from the rest home) said that the care provided is excellent.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.
D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Personal belongings are documented and included in residents' files.
D4.1a All six residents' files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service gathers appropriate spiritual, religious and cultural information that is relevant and sufficient to support an appropriate response to the needs of residents. Resident care plans identify the cultural needs, religious values and beliefs of the residents. Planning is done in conjunction with the resident and their whanau.

There are current guidelines for the provision of culturally safe care for Māori residents. This covers cultural safety and Māori health procedures. These guidelines support staff to identify and respond to cultural values and beliefs. Discussions with all six caregivers who work in both the rest home and the hospital and a registered nurse indicated that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori. They understand the importance of whanau.

Individual cultural values are identified and documented through the assessment and admission processes and staff make every effort to assist residents to practice their cultural values. Special events and occasions such as Matariki are celebrated at Thornton Park Retirement Lodge.

There were thirteen Maori residents currently living at the facility. One Maori resident was available to be interviewed and reports her cultural needs are being met. Two of two Maori residents' files audited include spiritual and cultural information specific to each Maori resident.

A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)
D20.1i The service has developed a link with local Maori authorities in the community. Many staff also identify as Maori.

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service provides a culturally appropriate service by implementing the Thornton Park Retirement Lodge philosophy that focuses on treating each resident as an individual and assisting them to meet their individual living requirements. During the admission process, a registered nurse along with the resident and family/whanau complete the documentation. There is a cultural policy that provides details of cultural safety in practice. The assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. Initial and on-going assessment includes gaining details of people's culture, beliefs and values. Families are actively encouraged to be involved in their relative's care in whatever way they want, for example, taking them to appointments or outings. They are able to visit at any time of the day.</p> <p>D3.1g The service provides a culturally appropriate service by celebrating culturally specific holidays and providing residents with culturally appropriate foods.</p> <p>D4.1c All six care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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: 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 all six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) identify that privacy is ensured. Discussions with all four caregivers who work in both the rest home and the hospital and a registered nurse can describe how professional boundaries are maintained.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

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. A quality monitoring programme is implemented that monitors contractual and standards compliance and the quality of service delivery.

All six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) spoke very positively about the care provided.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for caregivers and registered nursing staff that adhere to the health and disability services standards. There is an implemented quality improvement programme that includes performance monitoring (reference 1.2.3).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an open disclosure policy, a complaints policy and an accident/incident policy.

The service continues to manage communication well;

Six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) stated they were welcomed on entry and were given time and explanation about services and procedures.

Resident meetings occur every three months. There are regular newsletters and the manager has an open-door policy.

The service has an interpreter and translation services policy, which includes information about accessing these services. Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.

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.

D16.4 All three relatives stated that they are always informed when their family members health status changes or in the case of an adverse event occurring. This was also verified in the review of all fifteen completed accidents/ incidents forms reviewed.

D11.3 The information pack is available in large print and 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: Policies and procedures are in place for obtaining informed consent. Written consent is obtained for sharing of information, photographs, transport, treatment, choice to withdraw consent, and obtaining medical attention in the event of illness and accident. All advance directives viewed in six of six residents' files are signed appropriately. D13.1 there were six admission agreements sighted and all six had been signed on the day of admission. D3.1.d Discussion with three family identified that the service actively involves them in decisions that affect their relatives lives.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The clients' right to access advocacy services is identified for residents. Leaflets are available at the entrance of the service. The information identifies whom the resident can contact to access advocacy services.

The information pack provided to residents prior to entry includes advocacy information.

Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed.

D4.1d; Discussions with all six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) identified that the service provides opportunities for the family/EPOA to be involved in decisions and that they are aware of their access to advocacy services.

There is an example of one complaint/concern that was lodged whereby the facility contacted the HDC Advocacy Services on behalf of the client.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are no set visiting hours.

D3.1.e Discussions with all four caregivers who work in both the rest home and the hospital, a registered nurse, all six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) identified that residents are supported and encouraged to remain involved in the community and external groups. Residents are encouraged to access services within the community wherever appropriate and/or requested and support is provided to achieve this. Examples are visits to the hairdresser, local church services and local clubs.

D3.1h; Discussions with three family identifies that they are encouraged to be involved with the service and care of their family member.

D3.1.e Discussions with four caregiver staff, and one registered nurse and three relatives confirms that they are supported and encouraged to remain involved in the community and external groups.

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

Consumers have access to visitors of their choice.

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

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

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

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

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:

There is a complaints policy that complies with Right 10 of the Code. 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 to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau.

All six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) confirm they are aware of the complaints process and they would make a complaint to the manager if necessary.

There is an electronic complaints register that is up to date and includes relevant information regarding the complaint. Verbal complaints and concerns are also included. All documentation including acknowledgement letters, investigation reports and follow up letters is held with the Quality Improvement Form. Records demonstrate that complaints are well managed. There have been 24 complaints since the previous audit and all have been appropriately resolved in a timely manner.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>Thornton Park Retirement Lodge provides care for up to 42 rest home and hospital level care residents. At the time of the audit, there were 34 residents living at the facility including 17 at a rest home level of care and 17 at a hospital level of care. Thornton Park Retirement Lodge has a quality and risk management plan that includes its purpose, direction and objectives. Performance is monitored through an internal audit programme.</p> <p>The clinical nurse manager/RN is the manager for the facility, a position she has held for four years. She holds a bachelor's degree and a postgraduate certificate in nursing. She regularly attends professional development courses relating to the management of an aged care facility. In 2013 she attended an eight hour study day sponsored by the aged care association, infection control training, and clinical training provided by Waiariki Institute of Technology.</p> <p>ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.</p>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: During the temporary absence of the clinical nurse manager, the service is managed by the support officer and registered nurses. The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning.

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

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

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

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

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: <p>The service has a quality and risk management plan for 2013. The quality system and internal audit programme are designed to monitor contractual and standards compliance and the quality of service delivery. The clinical nurse manager reports this plan remains unchanged from the plan that was developed in 2011. There is an internal audit schedule. Internal audits are completed as per the schedule. Progress towards meeting the quality and risk management objectives is monitored through monthly coordinator (quality) meetings. Meetings includes (but are not limited to): remarkable internal audit results; satisfaction survey results; complaints; incident and accident analysis; infection control analysis; restraints; changes/additions to any policies and/or procedures; and staff training. Minutes are maintained and accessible to staff in a folder held in the staff room. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Thornton Park Retirement Lodge's commitment to on-going quality improvement. Discussions with four caregivers who work in both the rest home and the hospital and a registered nurse confirm their involvement in the quality programme. Resident and family meetings take place three monthly.</p> <p>D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. Clinical policies include: a) continence assessment policy; b) pain management policy; c) personal grooming and hygiene policy;</p>

d) skin management policy; e) wound care policy f) resident transportation policy; g) death and dying protocols h) management of challenging behaviour policy. There are infection control policies and procedures. There is a restraint policy and health and safety policies and procedures.

There is a document control policy. All policies and procedures are reviewed annually. Documents no longer relevant to the service are removed and archived.

a) The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an accident and incident policy. A 'harm and fall' form is completed and given to a registered nurse who completes the follow up (sighted in 15 of 15 'harm and fall' reports for the month of October 2013). Data is collected each month. An analysis of trends occurs. Results are discussed in the coordinators meetings. Meeting minutes are held in the staff room for review.

b) Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through residents meetings and surveys are followed up and actioned (reference 1.1.13).

c) Infection control data is collated monthly and reported to the monthly staff meeting. Caregivers who work in both the rest home and the hospital and a registered nurse interviewed feel well informed about infection control.

d) Actual and potential risks are identified and corrective actions initiated. This is discussed at the monthly coordinator meetings with the meeting minutes posted in a visible location. There is a hazard register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed six monthly and was last reviewed on.

Quality improvement data is analysed to identify trends and themes. This includes incidents, infections, hazards, audits and complaints. Results are communicated to staff and residents and family/whānau wherever appropriate as reflected in meeting minutes and feedback from the annual resident/relative satisfaction survey.

The service has an internal audit schedule that is implemented. Internal audits are completed and actions identified if required. Internal audits completed include (but are not limited to): safe use of restraints (23 Oct 13); informed consent and residents' rights (27 Sept 13); concerns and complaints (24 Apr 13); laundry (14 Mar 13); kitchen (24 Apr 13);

e) Restraint/enablers are reviewed at the coordinator (quality) meeting.

The service holds monthly staff meetings. Staff are expected to attend and attendance is good. The staff meeting minutes reflect feedback and analysis of quality data, internal audits and implementation of quality initiatives.

A process is implemented to measure achievement against goals in the business, quality and risk management plan. A formal review takes place annually.

Corrective actions are established as a result of internal audits, incidents, accidents, complaints and concerns. These are documented on quality investigation forms with actions completed being signed off by the clinical nursing manager.

Discussions with four caregivers who work in both the rest home and the hospital, a registered nurse, six of six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) demonstrate that suggestions and corrective actions are implemented.

D19.3 There are implemented risk management and health and safety policies and procedures in place including incident/accident and hazard management. The hazards management policy includes (but is not limited to): hazard identification; hazard management; staff responsibilities; employee participation in health and safety systems. The policy requires that all staff are informed of significant hazards and how to eliminate, isolate or minimise the impact of the hazard. There is also an accident and incident policy.

There is a hazard register that is reviewed six monthly. Hazard identification reports are completed to identify hazards with actions identified and reviewed/followed up

where appropriate. The monthly staff meeting identifies actual and potential risks and corrective actions are initiated. Monthly incident and accident data are collated and actual and potential risks are identified.

D19.2g Falls prevention strategies include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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.

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

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: <p>Discussion with the clinical nursing manager confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual quality investigation forms or harm and fall report forms are completed for each incident with immediate action noted and any follow up action required, evidence in the review of all fifteen harm and fall reports selected for review.</p> <p>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.</p>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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 is a human resources policy that establishes the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff. Relevant checks are completed to validate individual qualifications and experience. A record of current practising certificates is maintained.

The service has human resource policies that are sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. Human resource policies for the selection and appointment of staff are in place. Six staff files were randomly selected for review (two RNs, one cook and three caregivers). An employment contract was sighted in each staff file. Staff files also included evidence of police vetting.

There is a staff induction/orientation policy. Comprehensive orientation is provided for new staff. Evidence of completed orientation checklists were sighted in all six staff files reviewed. New caregiver staff are involved in a buddy system for two shifts working alongside an experienced caregiver. This is extended if necessary. Four caregivers who work in both the rest home and the hospital and a registered nurse interviewed could describe the orientation-training programme.

There is an in-service education policy. Discussion with the clinical nurse manager, four caregivers who work in both the rest home and the hospital and a registered nurse confirms that an in-service training programme is in place that covers relevant aspects of care and support and meets requirements. The annual training programme exceeds eight hours annually. Staff competencies completed in 2013 includes fire, health and safety, infection control, challenging behaviours, residents' rights, and chemical training.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to) medication management and CPR/first aid.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

Policies include staffing levels rationale and are based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

The service contracts with a physiotherapist on an as-required basis.

Thornton Park Retirement Lodge provides care for up to 42 rest home and hospital level care residents. At the time of the audit, there were 34 residents including 17 at rest home level and 17 at hospital level. Staffing is as follows:

Monday-Friday: clinical nurse manager 40 hours Monday - Friday. A registered nurse is on duty 24 hours per day, seven days a week. There is a support 42.5 hours per week on flexible hours.

There are four caregivers and one RN staffed during the AM shift. One RN and three caregivers work during the PM shift. One RN and one caregiver staff the facility during the night shift.

Staff turnover is low. The four caregivers interviewed stated that there is adequate staffing to manage their workload. Six of six residents (three from the hospital and three from the rest home) and three family members (two from the hospital and one from the rest home) interviewed report that staffing is adequate to meet the residents' 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.)*

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:

There are paper-based files appropriate to the service type available. Information is entered into the resident files in an accurate and timely manner to provide a sufficient record of care.

Residents' files are protected from unauthorised access by being locked away in a cupboard. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities staff. Medication charts are in a separate folder.

D7.1 entries are legible, dated and signed by the relevant caregiver or RN including designation.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents and/or family/whanau are provided with an information pack on entry to the service. The information pack includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code. The criteria for entry is for rest home or hospital level of care. The clinical nurse manager requires an approval of level of care from Support Net needs assessment team prior to entry.

There is an admission policy, a resident admission and orientation procedure and checklist.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member is informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available and if the client did not meet the level of care the facility provided.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

D.16.2, 3, 4: The six files reviewed (three hospital, three rest home) identified that an initial assessment was completed within 24 hours.

Information gathered on admission from Support Net needs assessment, discharge summaries, GP health records and letters, allied health notes, staff progress notes and discussion, resident/family/whanau participation and feedback provide the basis for the nursing long term care plan. All six files reviewed identify that the nursing long term care plan is completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. There is an improvement required around ensuring care plans reflect family input. Spirituality and cultural values and beliefs are included in the initial assessment and long term nursing care plan.

Activity assessments are completed by the activities person.

D16.5e: Six of six files reviewed 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 as stable and are to be reviewed three monthly. More frequent medical review was evidenced occurring in files of residents with more complex conditions or acute changes to health status. Residents retain their own GPs. The GP interviewed visits three monthly or more frequently as required. Staff notify the GP by fax or phone for more urgent concerns. The GP states RN concerns are received by fax/phone in a timely manner.

Clinical assessments and notifications are appropriate. There is a GP rostered on duty after hours.

A range of assessment tools have been completed in resident files on admission and reviewed three monthly for hospital level care and six monthly (or earlier) if applicable including (but not limited to); a) falls assessment and falls risk assessment, b) Braden, Waterlow pressure area risk assessment and ulcer risk assessment, c) continence and bowel assessment d) dietary assessment, e) pain assessment f) wound assessment

Clinical staff have undertaken education and training in areas of clinical care such as safe handling of residents and use of transfer equipment safety, skin and pressure area management, continence management, palliative care and challenging behaviour within the last year.

Tracer Methodology:

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: PA Low
Evidence: Staff could describe a handover that maintains a continuity of service delivery. All resident files (six) reviewed identified integration of allied health and a team approach. The podiatrist visits monthly. Residents and their family are made aware of the contents of the care plan. Families interviewed are complimentary of the care provided and confirm they are kept informed of any significant events and changes in health status
Finding: The six care plans viewed did not provide written evidence that the resident or family/whanau are involved in the care planning process
Corrective Action: Ensure there is written evidence of resident/family/whanau participation in the care planning process
Timeframe (days): 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA

Evidence:

Information obtained on admission interview includes (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, family/whānau support, activities preferences, food and nutrition information. Informed consents and resuscitation or end of life information is obtained in a timely manner. Nursing long term care plans reflect the assessments which are used as a basis for care planning. Residents and their family are made aware of the contents of the care plan and this information is available to other health professionals as needed (link 1.3.3.4). Residents advised on interview that assessments were completed in the privacy of their single room. A range of assessment tools have been completed in resident files on admission and reviewed three monthly for hospital level care and six monthly for rest home level of care (or earlier) if applicable including (but not limited to); a) falls assessment and falls risk assessment, b) Braden waterlow pressure area risk assessment and ulcer risk assessment, c) continence and bowel assessment d) dietary assessment, e) pain assessment f) wound assessment. Baseline observations of blood pressure, pulse, temperature and weight are recorded. Desired outcomes and goals of residents are identified. The RN completes an initial person centred care plan within 24 hours of admission. Continuing needs/risk assessments are carried out by a registered nurse. Notes by GP and allied health professionals are evident in six of six residents integrated files sampled. Families interviewed are complimentary of the clinical and medical care provided and confirm they are kept informed of any significant events and changes in health status.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The RN develops the nursing long term care plan from information gathered over the first three weeks of admission. The nursing long term care plan is focused on the resident with nursing interventions and support documented to meet the residents desired outcomes to promote wellbeing and independence. The resident records includes the residents medical diagnosis and any alerts. Nursing assessments included in the long term care plan are as follows: mobility, mental orientation, eating and drinking, personal cares and dressing, elimination, communication, sleeping, social, challenging behaviour, family/whanau, expressing spirituality/cultural needs, monitoring a safe environment, breathing, controlling pain, expressing sexuality, grieving and dying, skin integrity and other or special problems.

The resident file also contains the care progress notes; medical notes; referral letters; discharge summaries, risk assessment tools; observation recordings form; weight monitoring, laboratory results. Activities assessments and progress notes are also contained within the integrated file. Allied health professionals record their visits in progress notes in the integrated resident file.

Short term care plans are used to document any changes in health needs with interventions, management and evaluations. Three examples sighted were for weight loss, ankle injury and change in dietary needs, vomiting.

D16.3k: Short term care plans are in use for changes in health status.

D16.3f; Six resident files reviewed did not identify that family were involved. (link 1.3.3.4)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: PA Low
Evidence: <p>Care delivery is recorded by the RN/caregivers on each shift. Changes are followed up by registered nurses (evidenced in residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. The four caregivers interviewed stated that they have all the equipment referred to in long term care plans necessary to provide care, including gloves, aprons and masks. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence, wound care products and adequate linen supplies were sighted.</p> <p>Monitoring charts such as blood sugar levels, resident diet monitoring form, weight monitoring, blood pressure, oxygen saturations, temperature and pulse, restraint/enabler monitoring, ABC behaviour recording form.</p> <p>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 by referral to the Whakatane DHB and this process could be described by the clinical nurse manager.</p> <p>The clinical nurse manager described weight loss management. Residents are weighed monthly and any loss is actively managed with frequent weighs, food and fluid monitoring, high calorie foods and a trial of supplementary fluids. The GP is notified and a dietitian referral is initiated if required. The cook on interview is aware of residents with weight loss.</p> <p>Resident falls are recorded in the progress notes, reported to RN on duty and clinical nurse manager and are documented on accident/incident forms, family notified, GP notified, and interventions (examples sighted - review of medications, sensor mats, ensure mobility aids and call bell within reach, clutter free bedroom) are entered into a short term or long term care plan (sighted). Four week summary of falls is maintained and a frequent faller record</p>

details a 24 hour clock and times of falls. Information is analysed to manage falls prevention. A physiotherapist referral is initiated if required. Falls and significant events are discussed at handover.

AD18.3 and 4 Dressing supplies are available and a treatment room is well stocked for use. Wound assessments (include relevant history, type and body map) and wound dressing records are in place for eight residents. Wounds include a pressure buttocks and sacrum one graze to elbow and six skin tears (four residents). The district nursing service for wound care advice is readily available. RN's attend wound management education.

The community mental health nurse visits residents under the mental health services for the older person weekly and liaises closely with the psychiatric team. Identified behaviour problems are detailed in the long term care plan. An overt aggression scale is used to identify contributing factors for the behaviours, interventions and management. An ABC behaviour recording form is used for behaviour monitoring and interventions (sighted).

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: PA Low

Evidence:

Pain assessments forms are completed for three of six residents. The monitoring of the effectiveness of pain relief is recorded in the progress notes. Short-term care plans are used for short-term changes in condition or acute events.

Finding:

- i) There are no pain assessments in place for two residents Eg: rest home resident with frequent falls and prescribed prn pain relief as per the long-term care plan and one hospital resident with dementia who is on regular and prn pain relief as identified in the long-term care plan.
- ii) There is no short-term care plan in place for a rest home resident on return from hospital with medical and medication changes.

Corrective Action:

- i) Ensure pain assessments are completed for all residents who identify pain and are on regular or prn pain relief.
- ii) Ensure short-term care plans are in place for residents with short-term needs or changes to health needs.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The activities person is an RN employed 33.5 hours per week and who is currently progressing through diversional therapy (DT) qualifications. There is a DT assistant employed for 15 hours a week. Both activities persons hold a current first aid certificate and attend all relevant on-site in-service. The DT has attended cultural awareness/treaty workshop March 2012. The DT attends six weekly meetings with the Bay of Plenty DT group providing good networking and sharing of ideas. There is an interesting and varied combined rest home and hospital programme that includes; newspaper reading, exercise and sit dancing, housie, quizzes. One-on-one time for

hospital level residents include nail care, hand massage, conversation, reminiscing, wheelchair walks. There is a group of residents who go swimming at the Whakatane swimming pool. Meaningful activities are provided for individual residents with memory loss. Entertainment is scheduled twice a week and includes singing groups, piano accordion player, country and western singers. There are five residents under 65 residents for whom the DT develops an individual plan to incorporate their special interests and one on one time such as shopping, café outings as desired.

The residents enjoy visitors such as school groups and babies, church visitors, pets. There is a much-loved resident cat. Religious, ethnic and spiritual celebrations include Christmas, Easter, Matariki day, bible readings, weekly Anglican church services, catholic prayers and church visitors. Residents are encouraged to maintain links with the community are involved in hospice fund raising, red nose day, RSA, working men's club and ladies community project club. The activities team have access to two company vans (one with wheelchair) for regular outings and drives. A risk assessment prior to outings is carried out in consultation with the RN. The DT makes contact with a new resident and family as soon as possible after admission. The family are invited by letter to participate in the development of the activity care plan within six weeks of admission. The RN is involved in the activity care planning process. The activity care plan includes sections on; language, schooling/occupation/interests, values/beliefs, likes/dislike's, contacts, family/friends, personality, difficulties/physical challenges and other important information. Evaluations are completed six monthly and are coordinated to occur at the same time as the clinical care plan review. Daily individual resident activity records and progress notes are maintained. Family are invited to attend the resident quarterly meetings. The client/family completes a participation/satisfaction survey re in place.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at 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 RN evaluates the initial assessments within three weeks of admission. Long term care plans are reviewed and evaluated by the registered nurses three monthly for hospital residents and six monthly for rest home residents or when changes to care occur. Four of six long term care plans have been evaluated within the required timeframes and two residents have not been at the service long enough for an evaluation to occur. Written evaluations

include the resident goals as met or unmet for each section of the long term care plan and comments section. The review is discussed with the GP at their routine review of the resident three monthly. Letters are sent to the families to notify them of upcoming reviews, however there is no evidence of the resident/family/whanau participation in the review (link 1.3.3.4).

Short term care plans are evaluated at regular intervals and problems are either resolved or transferred to the long term care plan if the problem is ongoing.

D16.4a Care plans are evaluated three monthly for hospital residents and six monthly for rest home residents or more frequently when clinically indicated.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA

Evidence:

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation, reports and follow up required, investigations and results are maintained on resident files. Examples of referrals sighted were to physiotherapy, radiology, oncologist, podiatry, dietitian and Support Net needs assessment team. Allied health professionals record their visits in the allied health progress notes.

D16.4c: The service provided an example of where a respite (rest home level) was assessed for permanent rest home level of care. The support net assessment team are involved for re-assessments of residents to a higher level of care.

20.1; Discussions with registered nurses identified that the service has access to wound care nurse specialists, incontinence specialists, gerontology nurse specialists, mental health services for the older person, speech language therapist, physiotherapy and dietitian. The nurse manager described the referral process to access nursing specialists as required. Other specialist and consultant referrals are made by the GP.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There are policies and procedures in place for the co-ordinated and timely transition of residents to hospital or other services. The clinical nurse manager described the document and nursing requirements as per the policy for discharge and transfers. The documentation required includes transfer form, advance directive, drug chart and any other relevant information. The family are informed of any transfers. Previous transfer documentation and transfer summary is sighted in a residents file. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are medicine management policies and procedures in place to meet the legislative requirements for the prescribing and administration of medication. All medications are kept in a locked medication room. The supplying pharmacy deliver all pharmaceuticals and the monthly medico blister packs and collect returns as required. The RN checks all medications that come into the facility and signs the pack. An incoming medication stocklist is

maintained. The pharmacy checks all controlled drugs into the controlled drugs register and controlled safe with the RN on duty. There is evidence of weekly controlled drug checks and six monthly pharmacy checks. Registered nurses administer medications and undergo annual competency and education provided by the Medico representative. A signing register is in place. The RNs are supported by Whakatane hospice for palliative care residents. RNs attend syringe driver education and refreshers at the hospice. The medication fridge temperatures are monitored weekly and are within the acceptable range. All eyedrops in use are dated on opening. Standing orders are not used. Twelve administration signing sheets sampled are all signed correctly. As required (PRN) medications are dated and timed on administration. Twelve medication charts sampled all have photograph identification and allergy status documented. Caution and duplicate name labels are used.

D16.5.e.i.2; Twelve of 12 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: PA Low

Evidence:

There is one self-medicating resident at hospital level of care.

Finding:

The resident has not had a self-medication competency assessment completed. There is no evidence of self-medication monitoring in place.

Corrective Action:

Ensure self-medication competency is completed and monitoring of self-medication administration occurs.

Timeframe (days): 60 (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:

There is a cook and kitchenhand/dishwasher on duty each day. All meals and baking is cooked on-site. There is a rotating 30 day menu that caters for normal and soft diets, likes and dislikes. Seasonal availability is considered when menu planning. The dietitian (contracted through the DHB) has reviewed the menu (letter sighted). The main meal is midday. The cook receives a dietary requirements form for each new resident and is informed of any changes to the residents dietary needs. Dietary needs include normal, soft, pureed meals and specific requirements such as lactose intolerant diets. Likes and dislikes or any food allergies are recorded in comments section of the dietary requirements form. There is a communication whiteboard in the kitchen used by kitchen staff, caregivers and the RN that ensures dietary requests are met. The kitchen is well equipped to produce up to 37 meals per day. The equipment and sanitiser is serviced regularly. Freezer and chiller temperature recordings are conducted and within acceptable ranges. Daily cooking temperatures are recorded. All perishable foods in the chiller are date labelled. Staff on duty are wearing aprons, hats and gloves. Chemicals are supplied by Jasco's chemical supplier and stored safely. There are handwashing facilities within the kitchen, There is a kitchen cleaning checklist. There is adequate ventilation in the kitchen. Fly screens are in place on the external door and windows. Internal audit on food services and cleanliness audit was last conducted in October 2012. The kitchen staff meet with the manager monthly (meeting minutes sighted). Feedback on the service is received verbally and by way of quarterly resident meetings and surveys. Residents interviewed are very satisfied with the meals and baking. D19.2 staff have been trained in safe food handling. The cook on duty holds recognised qualifications.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a policy on the management of waste and hazardous substances. An internal audit to monitor the management of waste and hazardous substances was last conducted on 30 Jun 2013 with no corrective actions identified.

Staff interviews (one maintenance staff, one cleaner, one laundry staff, and four caregivers) confirm that management of waste and hazardous substances is covered during orientation of new staff.

Gloves, aprons and sterigel are readily available in numerous locations throughout the facility.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The building holds a current warrant of fitness, which expires on 26 June 2014.

There is a current approved evacuation scheme dated 28 September 2005.

Electrical equipment is checked annually.

Fire evacuation drills take place six-monthly with the most recent drill occurring on 10 October 2013. Fire drills are conducted by the Bay of Plenty Fire Service.

Maintenance is carried out as and when is necessary by an employed maintenance person who completes three monthly maintenance and inspection reports. Dates of preventative maintenance are held on an Excel spreadsheet. A system is in place to alert maintenance staff when preventative maintenance is due (eg, water temperature monitoring, fridge and freezer temperatures, equipment maintenance).

Water temperatures of residents' taps are monitored each week with temperatures ranging from 40 degrees Celsius to 45 degrees Celsius.

A building maintenance audit was last conducted 13 May 2013 with no corrective actions identified.

The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are carpeted and there are handrails. Residents were observed moving freely around the facility with mobility aids where required.

Pathways, seating and grounds are well maintained. The service has shaded areas for residents and outside seating areas.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. Interviews with four caregivers confirmed there was adequate equipment available.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: There are adequate numbers of showers and toilets available in each area in both the rest home and hospital. The toilet and shower facilities are distributed throughout the service enabling ready access by residents. Three showers are available in the rest home wing that are shared and one shared shower is located in the hospital wing There are an additional eight ensuite showers that are shared between two residents per shower. There is one visitor's toilet.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Resident rooms in the rest home and hospital are of an adequate size to allow for the safe use of mobility aids and hoists. There are two double rooms that are currently being used as single rooms. There are two large lounges and one small lounge. There are two dining area with one dining area designated for those who require

assistance with feeding.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a large lounge and a small lounge area. These are shared lounges between the rest home and hospital. The dining room is separated into two sections. The main lounge functions as the activities area.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Laundry and cleaning services are monitored by the housekeeping coordinator for cleanliness and effectiveness with the most recent audit on 14 Mar 2013. Disposable gloves and gowns are available in the laundry and two sluice rooms.
All chemicals are labeled with manufacturers' labels. MDSS are available in folders in the laundry and in the shed.
All chemicals are locked and not accessible by the public.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has in place a civil defense manual and civil defense plan. The manual and plan include (but are not limited to): a) an emergency plan checklist, b) emergency services and medical services contact details, c) civil defense guidelines for the Opotiki District council, d) radio station contacts, e) earthquake procedure, (f) flooding procedure, g) tsunami procedure, h) storm procedure, i) armed robbery procedure, and j) fire procedure. The civil defense manual also contains procedure information for evacuation.</p> <p>Staff orientation includes emergency and security training and staff has received training in emergency procedures.</p> <p>There is an approved and up-to-date fire evacuation plan dated 28 September 2005. Fire drills occur six-monthly. The Bay of Plenty Fire Service attends the fire evacuation drill once a year.</p> <p>The service has a functional back-up generator. There is also battery operated emergency lighting that can last for four hours before needing the generator. There are barbecues available in the event of a disaster should they be required. Bottled water is stored in two separate storage cabinets There are adequate water supplies for the residents (three litres of water per person per day). Extra blankets are available. There is a civil defense kit, which is checked annually, and outdated products are replaced.</p> <p>The service has a call bell system available in resident rooms, toilet/shower areas and communal living areas. During the audit, staff was observed ensuring call bells were within reach of the residents.</p> <p>The service has visitor security and safety procedures. Large gates are triggered by a push button as a security measure for the residents. There are some gates around the large grounds that are locked. There is no environmental restraint. One resident was observed freely leaving the facility in her mobility scooter.</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defense and other emergencies are included.</p>

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

General living areas and individual rooms are appropriately heated and ventilated. Three of the residents' rooms have an additional panel heater. Natural light is readily available in each resident's room.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint minimisation procedure includes that an enabler limits the freedom of movement of the resident, for example, a bed rail put in place at the resident's request for safety. The intention of the enabler determines whether or not a piece of equipment, device or furniture is an enabler. Where the intention is to promote independence, comfort and safety and the intervention is voluntary, this constitutes an enabler. There are five residents using an enabler. Residents using an enabler have given consent, evidenced in two of two residents' files reviewed who are using an enabler.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: PA Low

Evidence:

Responsibility for restraint coordination is delegated to a registered nurse but this responsibility has not been clearly defined. She is supported by the clinical nurse manager. Consultation occurs with the resident and/or their family prior to the use of any restraint. The restraint coordinator ensures all restraint minimisation and safe practice standards are met. She is responsible for maintaining the restraint register, provides staff education, maintains a register of staff who demonstrate competency in restraint minimisation, audits restraint practice, maintains regular communication with the family and GP and provides input to the restraint programme.

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

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

Attainment and Risk: PA Low

Evidence:

Responsibility for restraint coordination is delegated to a registered nurse but this responsibility has not been clearly defined. She is supported by the clinical nurse manager. Consultation occurs with the resident and/or their family prior to the use of any restraint. The restraint coordinator ensures all restraint minimisation and safe practice standards are met.

Finding:

Responsibility for restraint coordination is delegated to a registered nurse but this responsibility has not been clearly defined.

Corrective Action:

Ensure the restraint coordinator's role and responsibilities are clearly defined.

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint assessment process includes documenting any risks relating to the use of the restraint, the behaviours displayed that indicate the need for restraint, any existing advance directives (where applicable), any previous episodes of restraint use (if any), cultural implications, and possible alternative strategies that were trialled prior to initiation of the restraint. Three residents are using a restraint. Two of the three residents' files were selected for review. Both files included the restraint assessment process and links to the resident's individual care plan.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The restraint assessment form includes investigating alternative strategies, such as de-escalation strategies before implementing a restraint or enabler. Interviews with the restraint coordinator and clinical nurse manager confirm restraint is only used as a last resort.

Each episode of restraint is documented in sufficient detail on the restraint assessment form to support its use. Documentation includes the reason(s) for initiating restraint, and a record of consent signed by the restraint coordinator, the GP, RN and the family/EPOA. The outcome of restraint is documented in the -monthly evaluation of restraint/enabler. (Evidenced in two of two residents' files where restraints were in place).

The restraint register provides a record of restraint (and enabler) use including the resident name, date(s) when restraint is initiated, and date(s) when the restraint is discontinued (where applicable). Eight residents are listed on the restraint register. Three of the eight residents are using an approved restraint with the remaining five residents using bedrails as enablers.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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

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

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

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint coordinator or RN on duty reassesses each resident using restraint for their on-going restraint needs. Reassessments occur after the initial 72 hours of restraint use, one month following, and then 3-monthly thereafter (evidenced in two of two residents' files where restraint was being used). The restraint coordinator monitors the review of safe restraint practice. A system of evaluation and review of the restraint for the resident takes place during the monthly RN meetings. This review assesses the following: alternative strategies explored, desired outcome and whether it is being achieved, whether the restraint used is the least restrictive option, the duration of the restraint, the impact the restraint has on the resident, and were policies and procedures followed.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The restraint coordinator reports she is responsible for ensuring restraint use is actively minimised, monitored and reviewed for each episode of restraint use (link 2.2.1.1). The review of the restraint programme includes the review of restraint policies and procedures and review of the education programme for staff regarding the use of restraints and enablers (evidenced in restraint policy and interviews with the restraint coordinator and clinical nurse manager). Episodes of restraint use, trends and progress made in minimising restraint are reviewed in the nursing meeting minutes to ensure restraint is only used when necessary, appropriate and safe.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: PA Low
Evidence: The scope of the infection prevention and control programme policy are available. The clinical nurse manager is the infection control coordinator. The infection control coordinator provides monthly reports at the Quality meeting. Quality meeting minutes and reports are available in the staff room (sighted). Infection control is a set agenda item at all meetings. There is an infection control programme contained within the IC policy and procedure manual that is appropriate for the size and complexity of the service. Infection

control quality goals are incorporated in the organisational annual quality plan that is reviewed annually. The programme includes activities such as hand hygiene, internal auditing, education and surveillance. Visitors are encouraged to stay away if sick. There is a staff health policy in place to ensure staff do not spread infections. The facility has signage to use for outbreaks and displays this information as needed. There is adequate outbreak management personal protective equipment readily accessible for staff to set up bedrooms and toilets for isolation. There have been no outbreaks.

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

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

Attainment and Risk: PA Low
Evidence: The infection control coordinator is the clinical nurse manager and reports to the quality meeting.
Finding: The responsibilities for the infection control coordinator is not clearly defined.
Corrective Action: Ensure the responsibilities for infection control is clearly defined
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The quality meeting representatives include the infection control coordinator, support services manager, food services and laundry/cleaning coordinators and the clinical coordinator. Meetings are held monthly (minutes sighted). The facility also has access to infection prevention and control nurses from the Whakatane DHB, regional health protection officer and Bugs control IC consultant, G.P's and Laboratory services. Internet access is available.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D 19.2a: Thornton Park IC policies and procedures meet current accepted good practice and relevant legislative requirements. Policies are referenced where relevant to Bugs Control. The manual includes (but not limited to) policies on hand hygiene, standard precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment.

Kitchen, laundry and cleaning procedures include infection control procedures. There is also policy on waste management and disposal.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control coordinator is responsible for coordinating and providing education and training to staff. The IC coordinator has attended education through the Whakatane DHB and N.Z. Aged Care Association study days. The IC coordinator is enrolled to attend an infection control course at the Waiariki Polytechnic in 2014. The IC coordinator has access to on-going education as needed. Staff complete hand hygiene competency and an infection control quiz on orientation and annually thereafter. Records of staff attendance is maintained.

Infection control education occurs as appropriate with individual residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. Standardised definitions of infections are in place and are appropriate to the complexity of service provided. Infection surveillance includes eye, skin/soft tissue, UTI, chest and other infections. Infection report forms are completed for all bacterial, fungal and viral infections. An individual resident antibiotic log is held in the resident's file. Data collection, trends and analysis are reported to the quality committee. Infection types and rates are graphed and available to staff. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Internal audits occur and where needed a corrective action plan is put in place.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>