

Kapsan Enterprises Limited

Current Status: 14 November 2013

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

Chadderton Rest Home is 23 bed rest home level of care facility, privately owned by a husband and wife team who both work at the facility. One owner is a registered nurse who oversees all residents' care, and one is an experienced business manager. On the day of the audit there are 20 residents.

There are nine areas identified as requiring improvement from this certification audit. They relate to communication, written consent, advance directives, environmental restraint, timeliness of general practitioner review at admission, service delivery plans, evaluation documentation and two areas of medicine management.

Audit Summary as at 14 November 2013

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 14 November 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Organisational Management as at 14 November 2013

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 14 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 14 November 2013

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 14 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk
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Infection Prevention and Control as at 14 November 2013

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 14 November 2013

Consumer Rights

Residents' rights are understood and maintained by the service. The Code of Health and Disability Services Consumers' Rights are discussed with residents and family/whanau upon entry to the service and are clearly displayed at the facility in both English and te reo Maori. Residents are treated with respect and service delivery ensures resident dignity, privacy and independence is maintained.

Staff implement safe cultural practice and the Maori Health Plan to provide resident care in a manner that allows individual and cultural values and beliefs to be met. Residents are free from discrimination and have access to advocacy or support services.

Informed consent requirements are clearly defined and residents and staff members interviewed confirm choices are provided and informed consent is facilitated. Two areas requiring improvement have been identified regarding consent processes. Chadderton Rest Home is required to ensure the consent process is valid for non-competent residents and to ensure only competent residents sign advance directives.

Links with community resources are supported and facilitated. Visiting is not restricted.

The right of consumers to make a complaint is understood, respected and upheld by the service. There were no outstanding complaints at the time of audit.

Organisational Management

The organisation's business, quality, risk and management plan identifies how services are planned to meet residents' needs for rest home level care. The organisation's purpose, values, priorities and goals are clearly set out. Deficits to service are managed through corrective action planning as appropriate.

The organisation has an established, documented quality and risk management system which is implemented to reflect the principles of quality improvement. Adverse events are recorded, reported and followed-up as required through the use of incident and accident forms.

Human resources management processes implemented reflect good employment practice and meet legislative requirements. Services are provided by staff that are suitably skilled and qualified for the role they undertake. There is a planned education calendar for 2013. The service implements safe staffing levels and a skill mix that ensures contractual requirements are met and resident safety is maintained.

Residents' records are documented in accordance with current accepted standards.

Continuum of Service Delivery

There is clearly documented process for entry to the facility. Admissions are managed in a timely manner. Ensuring residents are reviewed by the general practitioner in a timely manner during admission is an area requiring improvement.

Care and support is provided by a range of health professionals. This includes one of the owner/managers, who is a registered nurse, trained caregivers, a general practitioner and visiting health professionals.

Assessments are undertaken and used to inform care plans. While long term care plans are reviewed at least every six months, some care plans are not sufficiently detailed nor reflect the resident's current care needs. This is an area requiring improvement. Despite this, care is being provided which meets the residents' needs, as the care needs of residents are being effectively communicated via other mechanisms. Short term care plans are well utilised and reviewed as required. Whilst evaluations are undertaken, not all are complete or accurate; this is also an area requiring improvement.

Residents have access to a range of health services. Referrals and transfers are managed in the timely and appropriate manner.

Individual activities are planned to meet the needs of the resident and are culturally appropriate. The activities plan is displayed. Activity goals are detailed and ensure the provision of relevant and appropriate activities for each resident. Individual resident's previous interests, hobbies, culture and ability is considered.

There are documented up to date policies and procedures related to medicine management. Staff who administer medicines undertake annual competencies to identify they are safe to perform the role. Medicines are securely stored. The GP undertakes review of medicines at least three monthly. There are two areas requiring improvement related to medicine management; around ensuring documented medication management systems are implemented, and that all medicine management information is recorded to a level of detail to comply with legislation and guidelines.

Residents' nutritional needs are managed according to individual requirements and the menu is approved by a registered dietitian. There were no negative comments from residents or family on the days of audit.

Safe and Appropriate Environment

Chadderton Rest Home is an older building which offers an appropriate, safe environment for rest home level care residents. There is a documented emergency plan, including an approved evacuation plan, which is understood by staff. This includes the safe disposal of waste or infectious substances in a manner which keeps residents, visitors and staff free from harm.

All appropriate processes are undertaken to ensure the building warrant of fitness is maintained. Furnishings and equipment are appropriately maintained.

There are six double bedrooms and 11 single bedrooms all of which allow safe manoeuvrability for residents.

There are adequate numbers of toilet, hand washing, and bathroom facilities which are centrally located. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is heated by both gas and electricity and is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and are sheltered for residents' use.

Restraint Minimisation and Safe Practice

The service has one chair lap belt restraint in use and there are three residents who can only leave the grounds if accompanied by a staff member or an approved adult. Environmental restraint is clinically indicated in all three cases. While the other residents can either open the gates independently or staff open the gates for the residents this is not the least restrictive practice and is an area requiring improvement. There are no enablers in use. Policies and procedures implemented meet the required Health and Disability Services Restraint Minimisation and Safe Practice Standards.

Restraint education is offered to staff during orientation and annually thereafter. It is appropriate to the type of restraint used at the facility. The service maintains a restraint approval process, which includes enabler use.

Assessment processes are appropriate and monitoring is undertaken according to risk. This information informs resident care planning. Restraint use is re-assessed six monthly for individual residents, and a full quality review is undertaken annually to ensure policy compliance, safe use of restraint and staff compliance and understanding. Restraint is only used for safety reasons and this is fully understood by all staff.

Restraint use is reported at management and staff meetings as confirmed in minutes sighted. The limited family/whanau input is fully explained in residents' progress notes.

Infection Prevention and Control

Chadderton Rest Home has an infection prevention and control programme which was reviewed in 2013. The owner/registered nurse (RN) is responsible for facilitating the infection prevention and control programme. The owner/RN participates in ongoing education on infection prevention and control. Relevant policies and procedures are available for staff and all policies have been reviewed in 2012.

Surveillance is occurring for residents who develop infections. Staff are informed of residents with infection as a component of the shift handover processes. The overall infection rates are analysed monthly (number and type of infections) and the results communicated to staff at monthly staff meetings. Discussion on prevention strategies is also a component of staff meetings.

Education is occurring with residents on infection prevention activities and includes signage reminding staff and residents of effective hand hygiene practices.

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:	Kapsan Enterprises Limited		
Certificate name:	Chadderton Rest Home		
Designated Auditing Agency:	DAA		
Types of audit:	Certification		
Premises audited:	Alpers Avenue Auckland		
Services audited:	Rest home level residential aged care		
Dates of audit:	Start date: 14 November 2013	End date: 15 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:			20

Audit Team

Lead Auditor	XXXXX	Hours on site	15	Hours off site	8
Other Auditors	XXXXX	Total hours on site	8	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	4

Sample Totals

Total audit hours on site	23	Total audit hours off site	18	Total audit hours	41
Number of residents interviewed	5	Number of staff interviewed	7	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	13	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Wellington 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	Yes
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 Wednesday, 8 January 2014

Executive Summary of Audit

General Overview

Chadderton Rest Home is 23 bed rest home level of care facility, privately owned by a husband and wife team who both work at the facility. One owner is a registered nurse who oversees all residents' care, and one is an experienced business manager. On the day of the audit there are 20 residents.

There are nine areas identified as requiring improvement from this certification audit. They relate to communication, written consent, advance directives, environmental restraint, timeliness of general practitioner review at admission, service delivery plans, evaluation documentation and two areas of medicine management.

Outcome 1.1: Consumer Rights

Residents' rights are understood and maintained by the service. The Code of Health and Disability Services Consumers' Rights are discussed with residents and family/whanau upon entry to the service and are clearly displayed at the facility in both English and te reo Maori. Residents are treated with respect and service delivery ensures resident dignity, privacy and independence is maintained.

Staff implement safe cultural practice and the Maori Health Plan to provide resident care in a manner that allows individual and cultural values and beliefs to be met.

Residents are free from discrimination and have access to advocacy or support services.

Informed consent requirements are clearly defined and residents and staff members interviewed confirm choices are provided and informed consent is facilitated. Two areas requiring improvement have been identified regarding consent processes. Chadderton Rest Home is required to ensure the consent process is valid for non-competent residents and to ensure only competent residents sign advance directives.

Links with community resources are supported and facilitated. Visiting is not restricted.

The right of consumers to make a complaint is understood, respected and upheld by the service. There were no outstanding complaints at the time of audit.

Outcome 1.2: Organisational Management

The organisation's business, quality, risk and management plan identifies how services are planned to meet residents' needs for rest home level care. The organisation's purpose, values, priorities and goals are clearly set out. Deficits to service are managed through corrective action planning as appropriate.

The organisation has an established, documented quality and risk management system which is implemented to reflect the principles of quality improvement. Adverse events are recorded, reported and followed-up as required through the use of incident and accident forms.

Human resources management processes implemented reflect good employment practice and meet legislative requirements. Services are provided by staff

that are suitably skilled and qualified for the role they undertake. There is a planned education calendar for 2013. The service implements safe staffing levels and a skill mix that ensures contractual requirements are met and resident safety is maintained.

Residents' records are documented in accordance with current accepted standards.

Outcome 1.3: Continuum of Service Delivery

There are clearly documented process for entry to the facility. Admissions are managed in a timely manner. Ensuring residents are reviewed by the general practitioner in a timely manner during admission is an area requiring improvement.

Care and support is provided by a range of health professionals. This includes one of the owner/managers, who is a registered nurse, trained caregivers, a general practitioner and visiting health professionals.

Assessments and undertaken and used to inform care plans. While long term careplans are reviewed at least every six months, some care plans are not sufficiently detailed nor reflect the resident's current care needs. This is an area requiring improvement. Despite this, care is being provided which meets the residents' needs, as the care needs of residents are being effectively communicated via other mechanisms. Short term care plans are well utilised and reviewed as required. Whilst evaluations are undertaken, not all are complete or accurate, and this is also an area requiring improvement.

Residents have access to a range of health services. Referrals and transfers are managed in the timely and appropriate manner.

Individual activities are planned to meet the needs of the resident and are culturally appropriate. The activities plan is displayed. Activity goals are detailed and ensure the provision of relevant and appropriate activities for each resident. Individual resident's previous interests, hobbies, culture and ability is considered.

There are documented up to date policies and procedures related to medicine management. Staff who administer medicines undertake annual competencies to identify they are safe to perform the role. Medicines are securely stored. The GP undertakes review of medicines at least three monthly. There are two areas requiring improvement related to medicine management; around ensuring documented medication management systems are implemented, and that all medicine management information is recorded to a level of detail to comply with legislation and guidelines.

Residents' nutritional needs are managed according to individual requirements and the menu is approved by a registered dietitian. There were no negative comments from residents or family on the days of audit.

Outcome 1.4: Safe and Appropriate Environment

Chadderton Rest Home is an older building which offers an appropriate, safe environment for rest home level care residents. There is a documented emergency plan, including an approved evacuation plan, which is understood by staff. This includes the safe disposal of waste or infectious substances in a manner which keeps residents, visitors and staff free from harm.

All appropriate processes are undertaken to ensure the building warrant of fitness is maintained. Furnishings and equipment are appropriately maintained.

There are six double bedrooms and 11 single bedrooms all of which allow safe manoeuvrability for residents.

There are adequate numbers of toilet, hand washing, and bathroom facilities which are centrally located. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is heated by both gas and electricity and is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and are sheltered for residents' use.

Outcome 2: Restraint Minimisation and Safe Practice

The service has one chair lap belt restraint in use and there are three residents who can only leave the grounds if accompanied by a staff member or an approved adult. Environmental restraint is clinically indicated in all three cases. While the other residents can either open the gates independently or staff open the gates for the residents this is not the least restrictive practice and is an area requiring improvement. There are no enablers in use. Policies and procedures implemented meet the required Health and Disability Services Restraint Minimisation and Safe Practice Standards.

Restraint education is offered to staff during orientation and annually thereafter. It is appropriate to the type of restraint used at the facility. The service maintains a restraint approval process, which includes enabler use.

Assessment processes are appropriate and monitoring is undertaken according to risk. This information informs resident care planning. Restraint use is re-assessed six monthly for individual residents, and a full quality review is undertaken annually to ensure policy compliance, safe use of restraint and staff compliance and understanding. Restraint is only used for safety reasons and this is fully understood by all staff.

Restraint use is reported at management and staff meetings as confirmed in minutes sighted. The limited family/whanau input is fully explained in residents' progress notes.

Outcome 3: Infection Prevention and Control

Chadderton Rest Home has an infection prevention and control programme which was reviewed in 2013. The owner/registered nurse (RN) is responsible for facilitating the infection prevention and control programme. The owner/RN participates in ongoing education on infection prevention and control. Relevant policies and procedures are available for staff and all policies have been reviewed in 2012.

Surveillance is occurring for residents who develop infections. Staff are informed of residents with infection as a component of the shift handover processes. The overall infection rates are analysed monthly (number and type of infections) and the results communicated to staff at monthly staff meetings. Discussion on prevention strategies is also a component of staff meetings.

Education is occurring with residents on infection prevention activities and includes signage reminding staff and residents of effective hand hygiene practices.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	43	0	2	4	1	0
Criteria	0	92	0	3	4	2	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Evidence of communication with family members or residents' legal representatives is not documented as occurring consistently in five of five residents' files reviewed, including in relation to falls, the development of infections, and commencement of new medications. One family member interviewed advised there is communication occurring from staff although it is not always timely. .	Ensure all residents and family/ legal representatives have full and frank information that reflects open disclosure principles.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Moderate			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Moderate	Two of six residents' files reviewed contain consent forms which have been signed by residents who are deemed by the general practitioner to not be competent in decision making. One of the residents with diminished competence has a welfare guardian/enduring power of attorney activated.	Ensure written consent is obtained from competent residents, and where a resident is not competent, that consent is obtained from the resident's legal representative.	90
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	Two of six residents' files reviewed contain an advanced directive that does not comply with required standards. One of the resuscitation documents is signed by the resident's daughter (the resident has diminished competence); the other resident signed their advanced directive and the GP has noted the resident has 'no insight'.	Ensure that advanced directives are valid and meet legal requirements.	180
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 Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	One of five resident's whose file reviewed was not seen by the GP within two working days of admission. Chadderton Rest Home did not have a copy of medical records evidencing the resident had been seen by a medical practitioner within two working days prior to admission.	Ensure records are available to demonstrate that residents are consistently reviewed by the general practitioner within timeframes to meet the Aged Related Care Contract (ARCC).	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	While it is sighted at audit that staff are providing care to meet resident's needs, three of five residents' care plans reviewed are not sufficiently detailed to guide staff in the provision of resident's care. Missing from the care plans is guidance for the caregivers in relation to the care of a resident with: - diabetes (who is on insulin and has elevated blood glucose levels) - seizures - incontinence - one resident with challenging behaviours	Ensure that care plans are sufficiently detailed to guide staff in the provision of individualised resident care.	90
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		comprehensive and timely manner.				
HDS(C)S.2008	Criterion 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.	PA Moderate	Not all components of care are evaluated. One resident's evaluation stated that no falls have occurred at the time of evaluation however the incident and accident documentation identifies that three falls have occurred over this time. Staff report that a resident is exhibiting challenging behaviour towards staff however these events are not being documented on behaviour management charts.	Ensure the residents' current needs are reflected in evaluations.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			
HDS(C)S.2008	Criterion 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.	PA High	During the observed medicine round a box of non-prescribed medicine was found in the medicine trolley drawer. When the staff member was asked about this she replied that it is given to residents who have an 'upset tummy'. The staff member did not seem to think it was wrong to give this medication and said that it is not documented on the medicine charts.	Ensure all documented medicine management systems as described in policy and procedures are implemented and staff who administer medicines have a complete understanding of all safe medicine management practices.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				One box of expired PRN medicine was also found. Both these items were removed on the day of audit. The RN could not explain why this process occurs.		
HDS(C)S.2008	Criterion 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.	PA High	<p>Eight of 10 medication files do not have documented parameters around the use of pro re nata (PRN) medication. This includes a resident who requires Actrapid Insulin for blood glucose levels above 18 mmol of glucose. The frequency staff are required to test blood glucose levels is not documented.</p> <p>A resident has codeine 15 mgs charted PRN up to three times a day. The timeframe between doses is not detailed and while staff comply with the requirements, on occasions, the interval between doses varies significantly.</p> <p>2. One file also showed that no timeframe for the giving of medication is charted.</p>	Ensure medicine management information is recorded to a level of detail to comply with legislation and guidelines.	30
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least	PA Low	Independently mobile residents are restricted	Ensure that all residents who are assessed as safe	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.		by the electronic gates in the driveway. While some residents are able to leave the grounds independently using buttons at the gate; other residents require staff open the gates as and when required.	and independently mobile, have the freedom to come and go from the site as they please.	

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:

Seven of seven staff interviewed from across the organisation (four caregivers, one activities coordinator, one cook and one laundry/cleaner worker) and two of two owners managers, one whom is a registered nurse (RN), are able to verbalise their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and provide practical examples of how these are practiced/implemented daily. Staff are observed ensuring resident privacy during cares, providing residents with choices, calling residents by their preferred name, and respecting the residents' right to refuse components of care.

Education related to the Code is included in staff orientation and is ongoing as part of regular in-service education - last presented in September 2013 and 10 staff attended.

Five of five residents and two of two family/whanau interviews confirm that residents are treated with respect and understand their rights.

ARRC requirements are met.

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:

Information about the Code is discussed as part of the admission process and this is included in written information given to all residents. This is confirmed by the two owner/managers and during five of five residents and two of two family/whanau interviews.

Residents have an information booklet which contains details related to the service provision at Chadderton Rest Home and this includes the Code in English and Maori, security, meals, visiting, activities, and advocacy services details and contact numbers. Discussions relating to residents' rights and responsibilities also take place as applicable following admission with the resident and family/whanau as appropriate. Both family/whanau members confirm they were provided with relevant information upon admission. Posters related to resident rights are displayed in the lounge in both English and Maori.

Education on residents' rights, advocacy, independence and individuality was held on 6 September 2013 and attended by 10 staff (records sighted).

Information about advocacy services including the Nationwide Health and Disability Advocacy Service are contained in the resident information booklet and contact details and phone numbers are on clear display in the hallway by the nurses' station.

Interviews with five of five residents confirm they are aware of their right to use advocacy services and one resident explained that they have contacted a service in the past to answer some questions they had.

ARRC requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

Stage one: The service has policies which identify various types of abuse, privacy and dignity, sexuality and spirituality. Procedures identify actions staff take to implement policies.

Stage two: Interviews with five of five residents and two of two family/whanau members confirm that their personal privacy is respected by the service. Family/whanau discussions are held in the manager's office and during audit residents often entered the office to discuss issues with the manager. There are locks on the toilet and bathroom doors to ensure privacy during personal cares. Bedrooms with more than one bed have curtains that allow visual privacy as appropriate. Residents have their own wardrobes and drawers to keep their personal belongings. Residents confirm they have full use of a portable telephone so they can talk in a private area as required. During interviews, residents reported the services they receive meet their needs, values and beliefs.

Interviews with seven of seven staff and two of two owner/managers also confirm staff understanding of meeting all residents' needs. This includes allowing residents to maximise their independence. One example given related to allowing residents to shower independently if they are able. Two resident interviews conducted were with residents who do not identify as European and they both confirm all their needs are met.

The family/whanau member of one resident report that staff actions and strategies used minimise risk to residents even when situations get a little tense. (The documentation sighted in five of five care plans does not always show this clearly as identified in criterion 1.3.5.2 in relation to the management of challenging behaviour).

As observed residents are addressed in a respectful manner and by their preferred names.

ARRC contract requirements are met.

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

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

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: Stage one: The service has guidelines for the provision of culturally safe services to Maori. Cultural needs are assessed as part of the admission process. A culturally appropriate person will be sought to act as advocate for the resident and family/whanau as required. Policy identifies both management and staff members' responsibility to ensure services are delivered in a culturally appropriate manner to meet residents' needs. The importance of family/whanau if reflected throughout the documentation

sighted.

Stage two: There are two residents who identify as Maori in Chadderton Rest Home. One file review included a Maori resident and care planning identifies how cultural needs are met. Examples sighted include not touching the resident's head without permission and karakia at meal time. During interview with the resident they stated that all their cultural needs are met by the services provided. This includes having a 'boil up' at least once a month. The resident has access to the local Marae which they have chosen not to use at the present time. Maori advocacy services are clearly identified and the service has support from the local Maori Community Centre. The resident confirms that family/whanau can visit at any time but that they do not wish family/whanau to be involved in their care planning at this stage. This is documented in the care plan sighted.

Interviews with two of two owner/managers (one is the RN) and seven of seven staff verbalise their knowledge and understanding of offering care that is culturally appropriate for all residents. Staff education is ongoing and cultural safety and awareness education occurred in September 2013 which was attended by 10 staff.

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

Stage one: The service identifies that culturally safe practice includes ensuring that all cultures, values and beliefs are recognised and respected.

The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support the needs of residents. Ethnicity, cultural and spiritual needs are identified during the initial assessment and the activities assessment and this is evident in the five residents' records sampled. Information on individual spiritual and cultural needs is not consistently included in residents' care plans reviewed and this is raised as an area for improvement in 1.3.5.2. Despite this the seven staff interviewed are able to verbalise individual resident's cultural and spiritual needs and provides examples of how these are facilitated. Five residents and two family members interviewed (including two resident interviews conducted with residents who do not identify as European). All five residents indicate that they are consulted in the identification of spiritual, religious and/or cultural beliefs and individual needs are being met. The family of one resident audited confirm they regularly bring the resident meals from home as part of the strategy of ensuring cultural needs are being met.

The activities coordinator advises (and verified in the activities plan) that the catholic priest visits weekly on Friday and provides communion for applicable residents.

The ARRC requirement is met.

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: A review of policies, procedures and guidelines, staff and resident interviews and observations, confirm that residents are protected from discrimination, coercion, harassment or exploitation. Any form of discrimination is not acceptable within the organisation as verified with interview with the owner/RN and allegations will be investigated and followed up. Seven of seven staff interviewed advise they are not able to accept gifts or money from residents or their family members. Five residents and two family members interviewed confirm they are treated with dignity and respect and are not subject to discrimination.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk:FA

Evidence:

Management ensures the required policies, procedures, and guidelines are documented and available for staff. Policies sighted reflect current accepted practice. There is adequate equipment and products (including wound and continence products) provided available for residents. Whilst care plans are not sufficiently documented and identified as an area for improvement in 1.3.5.2, the health care assistants are providing timely and appropriate care.

The GP interviewed states that appropriate interventions are implemented for the management and treatment of health care needs. Improvements are required in relation to medication management. These are raised in 1.3.12.1 and 1.3.12.6.

Support and input into service delivery is obtained for applicable residents from the mental health service for older persons (MHSOP) and the Huntington Chorea resource nurse and speech language therapist.

There is adequate numbers of sufficiently trained staff on duty at all times.

The relevant ARRC requirements are met.

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:PA Low

Evidence:

Policies detail that communication with residents and families is to be in an open manner. Evidence of communication with family members or a resident's legal representatives is not documented as occurring consistently in five of five residents' files reviewed, including in relation to falls, the development of infections, and commencement of new medications. This is an area requiring improvement

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:PA Low

Evidence:

Policies detail that communication with residents and families is to be in an open manner. Evidence of communication with family members or a resident's legal representatives is not documented as occurring consistently in five of five resident files reviewed, including in relation to falls, the development of infections, and commencement of new medications. The RN/owner confirms family are not always advised unless the event is 'significant'. One family member interviewed advised there is communication is occurring from staff although it is not always timely. Another family member advises not having been contacted about falls or changing health status and reports to have not visited the resident/facility in a while. The family member confirms being unconcerned about the absence of communication however, has not informed the managers/owners of the need not to be informed of minor issues. Staff have been provided with training on communication (October 2013) and complaints and open disclosure (September 2013). The in-services are attended by 11 and 10 staff respectively.

The four caregivers and activities coordinator advise the managers are responsible for communication with family where this is required.

All current residents speak English. The managers and staff are able to identify how interpreters can be accessed where this is required.

Finding:

Evidence of communication with family members or residents' legal representatives is not documented as occurring consistently in five of five residents' files reviewed, including in relation to falls, the development of infections, and commencement of new medications. One family member interviewed advised there is communication occurring from staff although it is not always timely. .

Corrective Action:

Ensure all residents and family/ legal representatives have full and frank information that reflects open disclosure principles.

Timeframe (days):180(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: PA Moderate
Evidence:
<p>Stage one: Policy covers all aspects of informed consent and is in accordance with the Right 10 of the Code of Health and Disability Services Consumers' Rights. There are specific forms for written informed consent. This includes advanced directives related to resuscitation. The service acknowledges every person's right to make decisions and to open and honest communication.</p> <p>Four caregivers and the activities co-ordinator advise residents have the right to refuse treatments and cares and should this occur the managers would be informed. On occasions the staff negotiate with the resident and provide alternative care. This includes offering a wash if the resident does not want a shower. Resident's participation in activities is voluntary. Training was provided to staff on resuscitation/advanced directives and informed consent on 6 September 2013. Ten staff are noted as attending.</p> <p>Written consent forms are sighted in all residents' files. On occasions they have been signed by residents with diminished insight/competence and this is an area requiring improvement. Advance directives/resuscitation decisions are also noted to be obtained from a non competent resident and on another occasion from a resident's family member. This is also an area identified as requiring improvement. One resident confirms being provided with choice on daily activities and that identified requests are respected by staff.</p>

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: PA Moderate
Evidence: Written consent forms are present in all five resident files reviewed during audit. The consents include consent for care/treatment, keeping clinical records, participation in activities/transport and consent for the resident's photograph to be used to assist with identification purposes. Two of six residents' files reviewed contain consent forms which have been signed by residents who are noted by the general practitioner to not be competent in decision making. The sample size was increased by one when non conformity was initially identified. One of the residents with diminished competence has a welfare guardian/enduring power of attorney activated.
Finding: Two of six residents' files reviewed contain consent forms which have been signed by residents who are deemed by the general practitioner to not be competent in decision making. One of the residents with diminished competence has a welfare guardian/enduring power of attorney activated.
Corrective Action: Ensure written consent is obtained from competent residents, and where a resident is not competent, that consent is obtained from the resident's legal representative.
Timeframe (days): 90 <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:PA Low

Evidence:

Two of six resident files reviewed contain an advance directive that does not comply with required standards. One of the resuscitation decision making documents is signed by the resident's family member (the resident has diminished competence); the other resident signed their advanced directive and the GP has noted the resident has 'no insight'. Four residents have valid resuscitation document in their files. For three of the residents they are not for resuscitation. This decision/request is documented by one resident who is competent. The GP has identified resuscitation is not appropriate for three of the residents. One of whom is now receiving palliative care and the other two residents have progressing genetic illness.

Finding:

Two of six residents' files reviewed contain an advanced directive that does not comply with required standards. One of the resuscitation documents is signed by the resident's daughter (the resident has diminished competence); the other resident signed their advanced directive and the GP has noted the resident has 'no insight'.

Corrective Action:

Ensure that advanced directives are valid and meet legal requirements.

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

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

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

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

Attainment and Risk:FA

Evidence:

Stage one: Policy and procedures reflect the resident's right to advocacy and support from a person of the resident's choice.

Information about the right to advocacy and contact details for local services is included in the information pack given to residents and families during the admission process. This is verified by two of two family members interviewed. One resident confirms having family regularly visit who provide support. This is verified by a family member who confirms visiting the resident at least three times a week.

The five staff interviewed advise a number of residents do not have any family or friends visiting and work to provide a home environment.

Consumer rights training, including the right to advocacy / support has been provided for staff in September 2013 and attendance records are sighted. Interviews with five of five residents confirm they are aware of their right to use advocacy services and one resident explained that they have contacted a service in the past to answer some questions they had.

The ARRC agreements requirements are met.

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

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:
<p>There is an open visiting policy in place. Visitors are observed to be made welcome. Four staff interviewed advise a number of residents do not have visitors or have very infrequent visitors. One resident is sighted going off site with the resident's legal representative. Interviews with five residents and one family member confirms that residents may entertain their visitors in the main lounge, outside or in the privacy of their own rooms. One resident has the bedroom door left open when visitors are present as agreed with the resident and family members.</p> <p>Links with community resources are supported and facilitated. Residents are able to go into the community on outings. Arrangements for attendance at specialist appointments and the GP are facilitated by staff as required. Other health professionals are involved with the provision of care. This includes speech language therapist, the Huntington Chorea resource nurse and mental health service older persons in the five residents' files sampled during audit.</p>

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: <p>Stage one: Policy states all complaints are followed up and trends are analysed in order for corrective actions to be put in place as required. The service acknowledges every person’s right to make a complaint. The owner/manager oversees the complaints process. The complaint will be acknowledged by the service within at least five working days. A complaints log is kept as a formal register of all complaints.</p> <p>Stage two: Both owner/managers confirm complaints management is discussed as part of the admission process and information is included in the resident welcome pack. A copy of the complaints form is available in the lounge and interviews with five of five residents and two of two family/whanau members confirm they understand the complaints process and are happy to register all concerns. The owner/managers operate an open door policy and residents can talk to them at any time.</p> <p>The complaints register sighted confirms that all complaints and concerns are followed up by management. All verbal complaints are documented. The complaints register identifies the name of the complainant, details of the complaint, the actions taken and by who and it is signed off by the owner/manager once resolved. All complaints</p>

sighted are of a minor nature. At the time of audit there are no outstanding complaints. One example relates to a resident who stated they would like their food to be warmer when served. This was discussed with the kitchen and appropriate follow up resulted in the resident being happy with the outcome. This was confirmed during interview with the resident.

Interviews with seven of seven staff confirm their knowledge and understanding of the complaints process and they all stated they implement this as per policy requirements. Staff have ongoing in-service education related to complaints management and this occurred in September 2013 and documentation reviewed identifies that 10 staff attended.

ARRC requirements are met.

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

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:

Stage one: The organisation's Business, Quality, Risk and Management Plan (reviewed December 2012) identifies that the business plan drives the direction of the business. Quality is driven by the satisfaction of resident care outcomes. The organisation's mission statement and philosophy are clearly shown.

Stage two: Services described in the organisation's Business, Quality, Risk and Management Plan are implemented by the service to meet residents' needs. The organisation's mission statement, values, business objectives (2013/2014), building maintenance strategy, and financial budgets and goals are clearly shown. Planning identifies how quality improvements are undertaken for all aspects of service delivery. Quarterly management meeting minutes show that all aspects of service are planned and discussed, including corrective action planning when a deficit is identified.

Overall service delivery is undertaken by the owner/managers who both actively work in the business. One looks after the non clinical areas and holds a post graduate diploma in management from Auckland University. The other owner/manager oversees all clinical care and is a RN with a current practising certificate. She has an up to date portfolio which identifies all Nursing Council of NZ requirements are met. Both owner/managers undertake education related to their roles including Auckland Hospital District Health Board education days, EMA education, New Zealand Aged Care Association training/seminars, and they have a current first aid certificate.

The results of the 2013 resident satisfaction survey and interviews with five of five residents and two of two family/whanau members confirm the services offered meets their needs.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: Interviews with both owner/managers confirm that they do not take leave at the same time so that one of them is always available as required. The service has a casual enrolled nurse who covers for short term leave for the RN owner/manager and a RN who is experienced in aged care works on short term contract as required.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

Stage one: The organisation's Business, Quality, Risk and Management Plan has goals and objectives showing that residents and their family/whanau are the prime focus of planning, evaluation and delivery of services. Goals and objectives are set out into groups:

- the consumer
- provision of effective programmes
- certification and contractual requirements
- quality and risk management processes
- continuous improvement

Corrective action processes include monitoring, assessment, actions, evaluation and feedback.

Regular staff meetings provide a forum for discussing quality issues. This is evidenced in minutes of staff meetings. There are comprehensive health and safety procedures for staff to follow. They involve hazard reporting processes and injury prevention processes.

Stage two: Quarterly management meeting minutes identify that the owner/managers discuss, evaluate and ensure corrective action planning is undertaken when an area of non-conformity is identified. This covers all aspects of service delivery. Policies and procedures sighted are up to date and reflect current good practice and meet legislative requirements.

The quality and risk management system implemented by the service includes regular internal audits (folder sighted), complaints management, data collection and trending for key performance components of service, such as, incidents and accidents, restraint, health and safety and infection control, and hazard identification processes. Information is shared with staff as identified in staff meeting minutes and staff interviews confirm they understand and are kept informed of quality improvements and corrective actions. Staff reported that one quality improvement which has made a big difference is the employment of a dedicated activities person five days a week. This has lowered the challenging behaviour incidents, as confirmed in data sighted. (Incidents occurred up to five times a month and since the activities person has been employed an average of one incident a month has been recorded over a five month period).

Data is collated and analysed and is used as an opportunity to improve services via corrective actions which are put in place for any deficit that is noted. Quality improvements show the issue found, the corrective action taken to address the issue and the date the action was put in place. One example sighted relates to the organisation's identification of poor use of behavioural monitoring forms. A memo was sent to all staff and an in-service was undertaken in October 2013 which 10 staff attended. (Refer comments in criterion 1.3.5.2). Another example relates to the identification of the need to increase laundry/cleaning hours. This has occurred as identified on the roster sighted. The laundry/cleaner staff person reports that this has prevented a build-up of dirty laundry in the morning and that the residents' toilets are cleaned more frequently.

Actual and potential risks are identified and documented in the hazard register. They are communicated to staff and residents as appropriate. Hazards are reviewed at the quarterly management meetings and discussed at staff meetings. Staff confirm during interview that they understand and implement documented hazard identification processes.

The 2013 resident satisfaction survey results show that residents are satisfied with services provided and no negative comments were made during resident interviews on the days of audit.

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

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

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>Stage one: Policy identifies that serious adverse events are reported to the Occupational Health and Safety department as required - specific accident investigation report forms sighted. All incidents and accidents are reported, recorded investigated and data is analysed. Information is trended and corrective actions are put in place to improve services as appropriate. Policy states all falls are recorded and investigated, ensuring appropriate assessments are completed.</p> <p>Stage two: Interviews with both owner/managers confirms their understanding of the need to undertake essential notification reporting and the circumstances this occurs. All incidents and accidents are recorded on a specific form. The form indicates who has been notified. Two of two family/whanau members report they are informed of incidents and accidents. One family/whanau member stated they only wanted to be alerted to serious incidents and this is identified in the resident's care plan. One family/whanau member stated that not all communication is timely. Refer to comments in criterion 1.1.9.1.</p> <p>Two of five residents interviewed stated they did not wish their family/whanau to be informed unless it was something very serious and they could not make decisions for themselves.</p> <p>In five of five resident file reviews there is a monthly incident/accident analysis form which shows the date, time area, injury (if applicable), cause and corrective action undertaken to prevent further incidents or accidents. One example relates to a resident who had increased falls, usually from the dining room table. All aspects of this situation were reviewed, a chair with arms was purchased and a medication review occurred. Only one fall has been recorded since these quality improvements have</p>

been implemented. This is confirmed in the resident's file. Trended data is shared with staff as sighted on the day of audit and confirmed during seven of seven staff interviews.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk:FA

Evidence:

Stage one: Policy and procedures identify how human resource management is undertaken in accordance with good employment practice and to meet legislative requirements. It identifies that professional qualifications are validated and that the manager ensures all staff work within their scope of practice.

There is a documented system in place to record annual practising certificates for staff that require them. Annual practising certificates are sighted for the RN, the GP and the pharmacy.

A review of seven of seven staff files (both owner/managers, one of whom is the RN, the activities coordinator, one cook, one cleaner/laundry person, and two caregivers one senior and one recently employed) and interviews with seven of seven staff confirm that the orientation process prepares staff for the roles they undertake. Documented orientation covers all aspects of service relevant to the role the employee undertakes. Staff files contain information such as job descriptions, signed agreements, up to date annual appraisals, education data including first aid and CPR training and orientation information; all of which are reflective of good human resource practices.

Every individual staff member has an up to date list of education undertaken. In-service and off site education offered is related to the role the staff member performs. Staff interviews confirm they are satisfied with the amount and type of education offered and that during annual appraisals they have an opportunity to identify any specific area of education they wish to pursue. There is an annual education calendar and staff are encouraged by management to attend all education offered. Aged Care Education (ACE) is available to staff and two staff are currently working towards gaining an ACE qualification.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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:

Stage one: Policy identifies how staffing numbers are maintained in case of sickness or planned leave.

Stage two: Staff work a set shift roster. This identifies that there are two caregivers on morning shift for eight hours.

-Afternoon shift has one caregiver for eight hours one caregiver for six hours and one support staff member for four hours.

-Night shift there is one caregiver for nine hours.

-A cleaner/laundry person works six hours, seven days a week.

-The activities coordinator works six hours a day Monday to Friday.

-One of the two owner/managers work at the facility each day. They do at least an eight hour shift Monday to Friday and reduced hours in the weekends. They are both on call and this is confirmed by staff interviews.

Staff confirm they have enough time to complete all tasks. If a staff member is sick or goes on annual leave staff cover is identified in the staff communication book as sighted. The GP is also on call and if they are not available they organise alternative after hours cover as required. The pharmacy also operates an out of hours call service.

Interviews with five of five residents and two of two family/whanau members and the results of the 2013 resident satisfaction survey identify services are delivered in a manner that meet 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:

An admission assessment includes verification and documentation of individual resident information. Review of five residents' records indicates that they include reports from all health professionals with the exception of the podiatrist who summarises visits in a designated exercise book. Progress notes are documented for almost every shift. And the caregiver records are integrated in the one file. Entries are legible, dated, and signed. A master signing sheet includes details of staff designations and this is readily available and current.

Residents' files are held securely in lockable cabinets at the staff station/desk and are sighted returned to the cabinet when staff have completed documentation.

The ARCC requirements are met. In the event of transfer to hospital at the District Health Board, a Chadderton RH resident transfer form is used. The RN/owner advises she is unaware of the yellow envelope process.

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:

The entry criteria, and assessment and entry screening processes are clearly documented. There is a pre-admission flowchart to guide staff on the pre-admission process. Residents are required to be assessed as requiring rest home level care, not require 24 hour RN care, not have significant behavioural issues and be a 'good fit' with other residents.

Adequate information about Chadderton Rest Home is provided. The owner/manager advises most of the facility referrals are via the mental health service.

The resident information pack includes the mission and values, admission process, rights and responsibilities, management of valuables and property, payment, confidentiality and complaints. The service operates twenty four (24) hours per day seven days per week.

Five residents' files are sampled. Evidence of the completed admission documents and needs assessments are sighted in all five files.

The related ARRC requirements are met.

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

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: There are adequately documented processes for the management of any declines to entry and waiting lists. The owner/manager advises no residents have been declined entry but in the event this was to occur, the prospective resident, family and referrer would be advised.

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

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; D16.5cj; 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 Moderate

Evidence:

Residents' and staff files sampled confirm that each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and reviewed by one of the owners/managers who is a registered nurse. Daily interventions and support with activities of daily living are implemented with the help of trained caregivers.

Timeframes for service delivery are defined and met as evident in four out of five residents' files sampled. An initial assessment is performed on admission by the RN and a medical assessment conducted by the GP within two working days. One exception is noted. One resident audited was not seen by the GP within this timeframe. Chadderton Rest Home did not have a copy of medical records evidencing the resident had been seen by a medical practitioner prior to the admission to meet the ARRC contract requirements. This is an area requiring improvement.

A short term plan is developed and implemented for the initial 21 days to guide staff. Following this the long term care plan is developed to include the identified goals of the resident. Short term care plans are also developed as and when required and care plan reviews are completed (at a minimum) every six months. It is noted that care plans are not sufficiently detailed to guide care for three of five residents whose records are reviewed. This is raised as an area for improvement in 1.3.5.2. Routine GP reviews are completed at the frequency determined by the GP and this can be monthly or every three months depending on the individual resident. The frequency for the ongoing routine GP review is noted by the GP at the current consultation.

Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement. For example, GP entries and visits from other health providers (Huntington's Chorea Resource Nurse, podiatrist, speech language therapist, mental health services older persons) are sighted in the total of five resident files sampled. Daily handovers also ensure continuity. During the audit one handover is observed. This is provided by the senior caregiver who is finishing a shift, however is attended by all current and oncoming staff as well as the activities coordinator. The handover sighted verifies accurate and comprehensive information on individual resident needs is communicated amongst staff.

Responsibilities for the provision of daily care is identified during the handover reports.

The relevant ARRC requirements are met with the exception of D16.5 e.

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

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

Attainment and Risk:FA

Evidence:

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

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>Timeframes for service delivery are defined and met as evident in four out of five residents' files sampled. An initial assessment is performed on admission by the RN and a medical assessment conducted by the GP within two working days. One exception is noted. The resident audited was not seen by the GP within this timeframe. Chadderton Rest Home did not have a copy of medical records evidencing the resident had been seen by a medical practitioner prior to the admission to meet the ARRC contract requirements. This is raised as an area for improvement. The RN is aware of the ARRC contract time frames and timeframes were met in the other four resident files sampled.</p> <p>A short term plan is developed and implemented for the initial 21 days to guide staff. Following this the long term care plan is developed to include the identified goals of the resident. Short term care plans are also developed as and when required and care plan reviews are completed (at a minimum) every six months. It is noted that care plans are not sufficiently detailed to guide care for three of five residents whose records are reviewed. This is raised as an area for improvement in 1.3.5.2. Routine GP reviews are completed at the frequency determined by the GP and this can be monthly or every three months depending on the individual resident. The frequency for the ongoing routine GP review is noted by the GP at the current consultation.</p> <p>The GP interviewed confirms his involvement in specialist referrals and medication reviews and states that he is always contacted regarding any concerns in a timely and proficient manner.</p> <p>Tracer methodology: XXXXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i></p>
<p>Finding:</p> <p>One of five resident's whose file reviewed was not seen by the GP within two working days of admission. Chadderton Rest Home did not have a copy of medical records evidencing the resident had been seen by a medical practitioner within two working days prior to admission.</p>
<p>Corrective Action:</p> <p>Ensure records are available to demonstrate that residents are consistently reviewed by the general practitioner within timeframes to meet the Aged Related Care Contract (ARCC).</p>
Timeframe (days): 90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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:
<p>The organisation completes a number of assessments during admission, inclusive of mobility needs, falls assessment, risk of challenging behaviour, dietary assessment, continence assessment (where applicable), pain assessment (where applicable), and communication assessment. The required assessments are sighted in five out of five files sampled. Base line observations of pulse, blood pressure and weight are also recorded on admission, and there after monthly (or more frequently if required). Blood glucose levels are monitored where indicated.</p> <p>The results of the assessment process is transferred onto the long term care plan with outcomes and goals documented. Assessments are reviewed by the owner. RN and assessments sighted are current. There is evidence of resident and family involvement in the assessment process. There are adequate areas within the facility to ensure assessments are conducted in private.</p> <p>The relevant ARC requirements are met. Long term care plans sighted have been completed within three weeks of entry (Although are not sufficiently detailed for three of five residents (refer to CAR 1.3.5.2)). Assessments sighted are commensurate with the resident's needs.</p>

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: <p>All five residents' files sampled have a care plan which has been reviewed in the last six months. The care plans are not sufficiently detailed to provide guidance to staff in caring for three of the five residents whose care plan is reviewed. This is an area requiring improvement. Despite this, staff are sighted to be providing interventions consistent with meeting the resident's needs, as other communication processes are in place and are effective. Short term care plans are developed as required.</p> <p>Residents' files sampled evidence integration (with the exception of podiatrist notes which are recorded separately). Currently sections exist in the residents' files for the documentation of assessments, care plans, progress, correspondence, medical notes, adverse events, consents, laboratory results, NASC correspondence, referral agencies, DHB letters and medical specialists records. Staff interviewed confirm they have access to residents' records and were sighted completing their progress notes on the day of the audit.</p> <p>Initial assessments are completed on admission and the five residents and two families confirm input in the development of residents care plans.</p> <p>ARRC contract requirements are met excluding D16.3d, and D 16.3 j.</p>

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

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

Attainment and Risk: PA Moderate
Evidence: <p>A short term care plan is developed on admission and a long term care plan developed within three weeks. The long term care plan is developed by the owner/RN and includes goals and interventions for personal hygiene needs, mobilisation needs, skin integrity, oral care, continence/elimination, fluid/ nutritional needs, sleeping requirements, quality of life and cultural needs, and behaviour. Interventions to ensure the resident's needs are met are not adequately detailed for three of five resident files reviewed. The care plan of a resident is missing information on cultural needs, pain management and management of insulin dependent diabetes. Another resident has occasional seizures. The component of the care plan detailing how these are to be managed is missing from the current care plan (although is present in the archived version). Another resident's care plan does not detail the managing of changing continence needs. This is an area requiring improvement.</p> <p>Short term care plans are developed when required. A number of short term care plans are sighted within the five residents' files sampled. For example, for the management of a urinary tract infection, boil, skin tear, swollen knee, development of peripheral oedema and dermatitis management. Short term care plans are reviewed regularly and closed out when discontinued.</p>
Finding: <p>While it is sighted at audit that staff are providing care to meet resident's needs, three of five residents' care plans reviewed are not sufficiently detailed to guide staff in the provision of resident's care. Missing from the care plans is guidance for the caregivers in relation to the care of a resident with:</p> <ul style="list-style-type: none">- diabetes (who is on insulin and has elevated blood glucose levels)- seizures- incontinence- one resident with challenging behaviours
Corrective Action: <p>Ensure that care plans are sufficiently detailed to guide staff in the provision of individualised resident care.</p>
Timeframe (days): 90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

Stage one: There are policies to guide staff in the management of clinical care in an up to date nursing manual.

Despite three of five residents' care plans not being sufficiently detailed, interventions are being provided by care staff to meet resident's needs. There is evidence that the level of assistance or supervision provided for activities of daily living are as agreed with the resident to optimise independence, where applicable, but ensure adequate supervision for the resident's safety. A resident who has occasional seizures. A seizure chart is maintained and review of the progress notes confirms seizures are being documented in the progress notes and on the seizure chart. Interventions and pro re nata (PRN) medication is provided to the resident during these events. Another resident is noted to having changing continence needs which have been addressed by staff with the provision of additional continence supplies. The resident audited is an insulin dependent diabetic and has episodes of challenging behaviour. The resident's BGL are tested at least four times most days and more frequently if the resident is unwell. The resident has been reviewed multiple times by the GP and adjustments made in the resident's medication. The resident is receiving a diabetic diet as verified during a visit to the kitchen. Several residents have been commenced on antibiotics for the treatment of urinary, respiratory and skin infections.

ARRC contract requirements are met.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The activities programme is appropriate and reflects that independence is encouraged and choices are offered. An activities assessment and goal plan is documented for all residents. This identifies personal interests and hobbies. Activities are then planned to help maintain skills and interests. An activities coordinator facilitates the programme which includes games, exercises, entertainment and outings. Records of attendance are maintained and participation is voluntary. Individual activities are also provided and this is sighted during audit. The activities coordinator is assisting a resident with passive exercises. The only female resident is 'pampered' by staff and sighted with her finger nails manicured and nail polish applied.

All residents interviewed speak highly regarding the variety of activities and outings that are provided. Preferences are considered and interests maintained. The current activity plan includes walks, games, exercise to music, a bus outing, indoor bowls, puzzles/word search, arts/crafts, quoits and karaoke. Residents' birthdays and other special occasions are celebrated. The Catholic Priest visits on Fridays to provide communion. Residents are sighted to be actively participating and enjoying the activities provided during audit.

The activities coordinator has attended the 18th National Diversional Therapy Conference in August 2013 (2 days) and participates in regular in-service. The activities coordinator has a current first aid certificate.

The relevant ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:PA Moderate

Evidence:

Six monthly reviews, as detailed in clinical policy occurs (or more often if required). All five residents' files reviewed evidence evaluation of progress in achieving long term goals on at least a six monthly basis. The evaluations for one resident audited are not accurate/complete. This is an area requiring improvement.

There is evidence of care being changed to meet resident's needs. This includes the provision of Actrapid insulin for elevated blood glucose levels, application of skin cream for dermatitis or dry skin, commencement of antibiotics and encouragement of increased fluid intake when residents are suspected or diagnosed as having a urinary tract infection. One resident has been commenced on diuretics and another resident has had pain medications adjusted. One resident has infrequent seizures. The incidents are reviewed by the GP during routine reviews.

The Clinical Manager is responsible for the review of care plans and maintains a schedule of when they are due. One resident audited and the family member interviewed verify being aware of the resident's elevated blood glucose levels.

Progress notes are documented by the caregivers most shifts and the RN as required. There is monitoring of residents food/dietary intake, completion of hygiene care and monitoring of urinary and bowel functions on a shift by shift basis.

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:PA Moderate

Evidence:

Six monthly reviews, as detailed in clinical policy occurs (or more often if required). All five resident files reviewed evidence evaluation of progress in achieving long term goals on at least a six monthly basis. The evaluations for the resident audited are not accurate. For example, it notes the resident has had no falls in the last six months. Copies of completed incident reports in this resident's file identifies the resident has had three falls within this period. Episodes of challenging behaviour are noted to have reduced. While caregivers verify this is correct, not all episodes of challenging behaviour are being documented on the challenging behaviour form. Where the challenging behaviour is displayed towards staff, the staff identify they de-escalate and manage each event and not all are documented on the behaviour monitoring form. This is an area requiring improvement.

The GP notes the results of laboratory and other requested investigations in the residents' consultation notes sighted. At least three monthly (or sooner where required), GP reviews are evident in all residents' files sampled. Short term care plans are documented as required (refer 1.3.6).

The resident audited and the family member interviewed verify being aware of the residents elevated blood glucose levels.

Progress notes are documented by the caregivers most shifts and the RN as required. There is monitoring of residents food/dietary intake, completion of hygiene care

and monitoring of urinary and bowel functions on a shift by shift basis.

ARRC contract requirements are predominantly met.

Finding:

Not all components of care are evaluated. One resident's evaluation stated that no falls have occurred at the time of evaluation however the incident and accident documentation identifies that three falls have occurred over this time. Staff report that a resident is exhibiting challenging behaviour towards staff however these events are not being documented on behaviour management charts.

Corrective Action:

Ensure the residents' current needs are reflected in evaluations.

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

The GP interviewed states that resident support for access or referral to another health and disability provider is facilitated in a timely and safe manner. The GP confirms his involvement in the referral process. The owner/RN states that a formal referral process exists which includes the identification of risk and involvement of the resident. Evidence of a recent referral is included in the five resident files sampled (refer to 1.3.3). This involves one resident who has been under the care of the Mental Health Services for Older People (MHSOP) team, two residents who are being seen by community resource nurses and a number of residents are receiving care provided by the

podiatrist.

Residents interviewed expressed no concerns about referral processes.

The ARRC requirements are met.

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

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: <p>Planned discharges or transfers are required to be conducted in collaboration with the resident/family. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a safe manner. There is a specific transfer and discharge procedure and form used to document the needs and requirements of residents during this process to ensure continuity of care. There is communication between staff and family relating to transfer or discharge.</p> <p>The GP interviewed confirms his involvement in the discharge/transfer process. The owner/RN states discharges to another facility occur when residents are deemed to require either hospital level care or specialised dementia care. In the event of discharge or transfer relevant components of the resident's records would be copied, including the contact details of the next of kin, current care plan, medication records, GP notes and copies of advanced directives, would transfer with the resident.</p> <p>The ARRC requirement is met.</p>

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

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 High
Evidence:
<p>Stage one: There is a full suite of procedures to guide staff in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> <p>Stage two: The medication system used by the service is robotic roll packs. Records sighted verify that all staff who administers medicines are competent to do so. Eight staff hold current competencies.</p> <p>There are clearly described reconciliation processes including a six monthly documented pharmacy reconciliation last undertaken on the 23 April 2013. The service has no standing orders. Policy describes that residents may self-administer medicines following a RN assessment. The RN advises that currently there are no residents who self-administer medicines.</p> <p>Areas for improvement identified during audit relate to the storage of non-prescribed medicines an expired medicine on the trolley and the poorly documented parameters around the use of pro re nata (PRN) medicines. Also one medication had no time for administration shown.</p>

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

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

Attainment and Risk:PA High

Evidence:

Ten of ten medicine file reviews show that there are resident photographs on each file, allergies are identified, and the record is pharmacy generated. Three monthly minimum medical reviews are undertaken.

Robotic medication pack rolls are delivered monthly from the pharmacy and are checked by a staff member. PRN medicines are also packed by the pharmacy. Any prescribed changes to medication results in a new robotic pack being made up and delivered by the pharmacy.

Medicines are safely stored in a locked medication trolley and in a locked cupboard at the nurses' station. Controlled drugs are clearly recorded and weekly checks are sighted. During the medicine audit the staff member observed doing the lunch time round undertook all required procedures described for safe medicine administration.

Medication errors are reported and investigated and discussed with the pharmacists/GP as applicable as described on incident forms sighted.

Areas identified for improvement relate to a non prescribed medicine being found on the trolley which a staff member stated is given for residents with stomach upsets (domperidone) and a box of medication had expired in August 2013. Both these items were removed at the time of audit and a discussion was undertaken with the RN.

Finding:

During the observed medicine round a box of non-prescribed medicine was found in the medicine trolley drawer. When the staff member was asked about this she replied that it is given to residents who have an 'upset tummy'. The staff member did not seem to think it was wrong to give this medication and said that it is not documented on the medicine charts. One box of expired PRN medicine was also found. Both these items were removed on the day of audit. The RN could not explain why this process occurs.

Corrective Action:

Ensure all documented medicine management systems as described in policy and procedures are implemented and staff who administer medicines have a complete understanding of all safe medicine management practices.

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

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

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

Attainment and Risk:FA

Evidence:

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

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

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

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

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

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

Attainment and Risk: PA High
Evidence: Staff sign to say they have given any prescribed medication. PRN medicines are charted by the GP; however, there are no parameters around the use of pro re nata (PRN) medicine use.
Finding: 1. Eight of 10 medication files do not have documented parameters around the use of pro re nata (PRN) medication. This includes a resident who requires Actrapid Insulin for blood glucose levels above 18 mmol of glucose. The frequency staff are required to test blood glucose levels is not documented. A resident has codeine 15 mgs charted PRN up to three times a day. The timeframe between doses is not detailed and while staff comply with the requirements, on occasions, the interval between doses varies significantly. 2. One file also showed that no timeframe for the giving of medication is charted.

Corrective Action:

Ensure medicine management information is recorded to a level of detail to comply with legislation and guidelines.

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

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

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

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

Attainment and Risk:FA
Evidence:

The service has a menu which has been approved as being suitable for rest home level care residents by a registered dietitian. The menu was reviewed and updated on the 8 November 2013. It is a four week rotating menu which the cook reports is followed at all times. There is sometimes a second choice offered, such as a 'boil up' for residents who wish to have this, and one Indian resident often has a curry.

Residents' nutritional needs are assessed upon entry to the service as confirmed in five of five file reviews. This information is shared with the kitchen. It is clearly identified in the kitchen what residents' nutritional needs, likes and dislikes are. Alternatives are always offered if a resident does not like what is on the day's menu. Interviews with five of five residents confirm they are happy with the food and that there is always plenty of it. This was also confirmed by one family/whanau member during interview.

The kitchen has adequate equipment. Food is rotated to ensure freshness. All decanted and frozen foods are labelled to identify date of purchase and/or date of expiry. Fridge and freezer temperatures are recorded daily and remain within the approved limits. The two cooks have completed safe food handling education. There is food and water for up to three days should it be required in an emergency.

ARRC requirements are met.

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

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

Attainment and Risk:FA
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: 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:

Stage one: Policy and procedure identify that all chemicals potentially hazardous to health are stored securely to minimise risk of accidental exposure. All waste is disposed of in accordance with infection control practices.

Stage two: Chadderton Rest Home provide a safe environment for staff and residents by ensuring the safe disposal of all waste, including hazardous substances. The owner/manager confirms there are no specific legislative requirements related to waste and all rubbish is taken by normal rubbish collection. There are yellow sharp containers for the correct disposal of needles and other objects classified as sharps. Chemical safety data sheets are sighted for all products kept at the facility. Seven of seven staff interviews confirm their understanding of correct waste disposal procedures as described in policy. Personal protective clothing such as disposal gloves and aprons are readily available for staff.

ARRC contractual requirements are met.

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

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: <p>All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 24 June 2014. A maintenance schedule is sighted for 2013/2014. Electrical safety testing occurred in February 2013.</p> <p>All biomedical and medical equipment which includes otoscopes, sphygmomanometers, stethoscopes, and chair scales had safety checks carried out by an approved provider in November 2013 - documentation sighted.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids, and walking areas are not being cluttered.</p> <p>Regular environmental audits are undertaken and follow up corrective actions are documented for areas that have a deficit identified. For example, the service has put an electronic lock on the front gate as it assists security and helps residents remain safe as the gate goes directly onto a main road. (Refer comments in restraint standards). The owner/managers ensure all maintenance is carried out as required. This is confirmed during seven of seven staff and five of five resident interviews.</p> <p>Residents have access to outdoor areas with appropriate seating and shaded areas. Residents were observed walking around inside and outside the facility, both independently and with the use of walking aids.</p> <p>ARRC requirements are met.</p>

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk:FA

Evidence:

Toilet and shower areas are centrally located and in close proximity to resident bedroom areas. There are separate staff and visitor toilet facilities. Hot water temperatures are monitored and documented to ensure resident areas remain within the safe limit of 45oC or less.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

There are six bedrooms with two beds and 11 single occupancy bedrooms. All rooms allow residents to move around safely with or without the use of mobility aids. Curtains allow residents visual privacy when they are in their bedrooms. Residents personalise their bed space. Interviews with five of five residents confirm they are satisfied with their bedrooms and confirm they can personalise them to meet their needs and likes.

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 maneuver 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:

Owing to the size of the facility all bedroom areas lead to the lounge and dining areas. It is non-cluttered and easy access. There are two lounge areas, one with a large screen television and one without. The dining area is separated by furnishings as the lounges and dining area are open plan. Activities occur in all of these areas as observed on the days of audits.

Interviews with five of five residents and two of two family/whanau members confirm the areas provided meet their needs.

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

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: Stage one: Policies and procedures are in place to guide staff. Job descriptions show responsibilities and tasks. Stage two: The company contracted to supply chemicals undertake a monthly sanitiser strength test for the washing machine to ensure laundry processes are effective. (Last undertaken 6 November 2013). An interview with the cleaner/laundry person and five of five residents confirm they are happy with state of their laundry. There is one each of commercial use washing machine and dryer in the laundry area, which is downstairs and kept locked when staff are not in attendance. Safety data sheets are available for all chemicals located on site. Cleaning supplies are kept on a specific trolley which is kept locked in a cupboard when not in use. Personal protective clothing and equipment sighted includes gloves, aprons and goggles. Staff interviews confirm this is readily available to them.

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

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 approved emergency evacuation plan signed off by the New Zealand Fire Service is dated 12 February 1993. There have been no changes to the facility foot print since this time. Six monthly trial fire evacuations are conducted - last undertaken on 30 July 2013. Staff emergency and security education update occurred in November 2013 and 10 staff attended. This education is also included in staff orientation as confirmed in seven of seven staff file reviews. Fire equipment was checked by an approved provider in June 2013.</p> <p>Civil defence and emergency supplies are checked six monthly. As confirmed by the two owner/managers there are emergency food and water supplies for up to three days if required.</p> <p>Records confirm that 11 staff hold current first aid certificates. This ensures there is always a qualified staff member on duty in case of an emergency.</p>

Staff are required to ensure doors and windows are securely closed at night. This is confirmed by two caregivers who work afternoon shift. The external electronic gate closes automatically and there is a manual override should it be required. There are close circuit television cameras which cover eight areas including the front door and the electronic gate. This can be monitored in the manager's office. There is always at least one of the owner/managers available on call.

Call bells are sighted in all resident areas. When the bell is activated a buzzer rings and a light shows up on a panel at the nurses' station. The call bells can only be turned off from the centralised nurses' station. Interviews with five of five residents confirm staff respond to the call bell within appropriate timeframes.

ARRC requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: All resident areas have at least one opening window and/or door which provides natural light and ventilation. The facility is heated by use of both electric and gas heating. The main lounge has a gas heater and each bedroom has a wall mounted electric heater which the resident can use as required. Resident interviews confirm the facility is kept warm at all times.

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

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

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: PA Low
Evidence:
<p>Policies and procedures are in place to guide staff with the safe use of restraint.</p> <p>The service has one chair lap belt restraint in use and three residents are under environmental restraint and can only go out of the electronic gate if accompanied by a staff member or an approved adult for the resident's safety. Other independently mobile residents are not able to leave the facility without staff opening the gate or the resident using the buttons at the gate to open the gate. This is an area requiring improvement.</p>

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:PA Low

Evidence:

Stage one: Policies and procedures are in place to guide staff with the safe use of restraint. Policy states that enablers are voluntary and the least restrictive option to meet residents' needs. There is a well-documented approval process and the only restraint/enablers approved are chair lap belts or bedside rails.

Stage two: The service has one chair lap belt restraint in use and three residents are under environmental restraint and can only go out of the electronic gate if accompanied by a staff member or an approved adult. All restraint is for safety reasons only. Other residents either use the buttons at the gate to open the gates or ask the staff to open the gate using a remote control. This is an area requiring improvement. Residents and family members interviewed did not identify/express any concerns with the gate being normally kept closed and or processes to open the gate.

Finding:

Independently mobile residents are restricted by the electronic gates in the driveway. While some residents are able to leave the grounds independently using buttons at the gate; other residents require staff open the gates as and when required.

Corrective Action:

Ensure that all residents who are assessed as safe and independently mobile, have the freedom to come and go from the site as they please.

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk:FA

Evidence:

Policy clearly indicates that the responsibility for restraint approval is overseen by the RN who is the restraint coordinator. The approval process is managed via the RN the owner/manager and the GP. The resident and family/whanau are involved as appropriate. Discussions with the resident's next of kin confirm that verbal consent has been given, as they do not visit on a regular basis. This is documented in the resident's progress notes.

The service has an electronic gate which can be opened by staff via remote control. From the road it can be opened by a button operation during daylight hours. Three residents who are not able to go outside the grounds, except when accompanied by a staff member or an approved adult, for safety reasons which are clinically indicated,

such as high falls risk if alcohol is consumed, lack of insight and displays of inappropriate behaviour in public, are clearly documented in residents' notes. Management of environmental restraint is identified in the restraint policy. Policy indicates that environmental restraint does not require monitoring and is reviewed upon request by the resident if they ask to go out.

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

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

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

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 service has an appropriate assessment form which covers the required criterion. An assessment form is completed by the restraint coordinator (RN) prior to restraint approval being sought from the approval group. There is a shortened version of this form for residents who require environmental restraint. The assessment for environmental restraint is supported by comments from the GP, such as lack of insight or high risk of falls if alcohol is consumed. This is clearly documented in the resident's notes and informs the decision to use environmental restraint.

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:
<p>Monitoring is decided according to identified risk. The resident with the chair lap belt is monitored at least two hourly. Forms are very detailed and state exactly what actions have been taken. The restraint coordinator confirms there have been no injuries related to restraint use.</p> <p>All restraint is documented in the restraint register (sighted). It identifies the resident byname, the date of the introduction of the restraint, and review date. Each monitored observation is recorded with the date and signature of the observer. The register identifies that only one resident has had restraint used for safety reasons following an increase in falls related to the resident's medical condition. There have been no falls recorded for the resident since restraint has been approved. All restraint is for safety reasons only.</p> <p>The environmental restraint is not monitored but it is recorded in progress notes who takes the resident out and for what duration.</p> <p>Staff undertake restraint and safe practice education during the orientation process and ongoing as part of in-service education. This was last presented in September 2013 and all 11 staff attended along with both owner/managers.</p>

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

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: <p>The service evaluates the resident with a lap belt six monthly via the evaluation group with family/whanau and resident input. This is identified on the care plan and in the restraint register. It encompasses a review of incidents and accidents to ensure residents remain safe and appropriately supervised when restraint is in use.</p> <p>Residents who have environmental restraint are fully informed and family/whanau or nominated representative are informed as appropriate. The RN audits the restraint monitoring forms at least monthly to ensure they are completed accurately.</p> <p>Seven of seven staff are able to verbalise their knowledge and understanding of safe restraint use. One resident who has environmental restraint in place stated they are aware of the reasons for requiring close supervision and that they often go out with a staff member to the mall.</p>

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

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:

An annual quality restraint use review sighted was undertaken in November 2013. It identified that the resident who has a lap belt in place did not have their consent form signed by the next of kin. The reasons for this are clearly stated and were confirmed by the family/whanau member when spoken to on the telephone on the day of audit. The restraint coordinator reports that the review is informed by information in the restraint register, outcomes of restraint audits and incident and accident information.

Policy identifies that restraint is used as a last resort and for safety reasons only.

Annual staff education related to restraint is compulsory and attendance is overseen by the RN restraint coordinator.

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: Stage one: There is a full suite of infection control policies which have been developed by an external infection prevention and control practitioner to ensure a suitable infection control programme is implemented by the service. The infection prevention and control programme includes specific goals and objectives. The infection control programme was reviewed at the end of 2012 and again at the beginning of 2013 as documented in the infection prevention and control plan sighted. The infection control programme details the responsibilities of the owner/RN (who is responsible for facilitating the IC programme). All five staff interviewed verify they are responsible for ensuring the use of personal protective equipment appropriately and undertake hand hygiene in a timely manner. The staff interviewed advise they inform the owner/RN or the owner/manager if they have any concerns about infection prevention and control activities or suspect a resident has an infection. This is verified in the five residents' files sampled and by interview with the owner/manager and owner/RN. .

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

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

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

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

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

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

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 infection control policy notes that the infection control nurse is supported by the GP (first point of call) and the pharmacist. Specialist advice / support can be obtained from wound care specialists, gerontology nurse specialists and nutritionists or the DHB infection prevention and control team if this is required.

The policy noted the rest home will be guided by the DHB in the event of an outbreak or pandemic. A monthly summary of all positive microbial results from residents is provided on a monthly basis from the laboratory (sighted). The owner/RN interviewed is happy the requirements of the IC programme are being met.

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

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: Stage one: All required policies and procedures are present. These have been developed by an external infection prevention and control specialist and reflect current accepted good practice and meet legislative requirements. These are readily available for staff and sighted at the staff station. All staff interviewed confirm policies are left accessible /available and the owner/RN communicates any key changes in content via handover and/or staff meeting.

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

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: <p>Infection prevention and control is included in the orientation and ongoing education programme for staff. This is verified during interview with five staff and the owner/RN and verified in records sighted. Eleven staff are sighted as having attended the most recent infection prevention and control education in-service on 30 August 2013. The owner/RN confirms she participates in relevant ongoing education on infection prevention and control topics and records sighted verify this. This includes having a current intravenous therapy competency, basic food hygiene certificate (October 2010), and completed an infection prevention and control workbook at in 2012 provided by a private surgical hospital in Auckland and attending the ADHB study day which included human immunodeficiency virus (HIV), wound healing and chronic obstructive pulmonary disease. Certificates of attendance or completion are sighted.</p> <p>Education is being provided to residents on infection prevention and control activities, including the need to ensure adequate fluid intake over summer to minimise the risks or urinary tract infections. Hand hygiene practices are encouraged via signage at resident hand basins.</p>

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

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

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: <p>Stage one: Surveillance data is used to trend the rate and type of infections. This is done by the infection control coordinator and a monthly report goes to staff and management.</p> <p>The infection control policy notes that surveillance for residents with infections will be ongoing. The types of infections included is appropriate to the service setting and includes:</p> <ul style="list-style-type: none">-respiratory infections- chest infections- gastroenteritis- skin and wound infections including fungal and scabies- systemic infections-ear infections- eye infections- urinary tract infections. <p>A template form is provided for the reporting of infections. Data sighted in the infection surveillance data is aligned with the information sighted in the five resident files reviewed. Short term care plans are developed and implemented when residents are diagnosed or suspected of having an infection. Infection rates are reported monthly per type of infection. A table of 013 data year to date is displayed on the staff notice board. This is visible to staff, residents and visitors. Overall there is between one and five infections reported per month. There is analysis of variances and likely contributing factors for infections each month.</p>

All five staff and the owner/RN interviewed are aware of their responsibilities in relation to the reporting and follow up of infections. Staff confirm they are advised of infections in a timely manner via handover processes and overall infection rates and trends are discussed at staff meetings. This is verified in staff meeting minutes sighted.

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

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>