

# Lexall Limited

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Current Status: 5 November 2013

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

## General overview

Lexall Care provides rest home and hospital level care for up to 58 residents. On the day of the audit, there were 24 residents in the rest home and six residents in the hospital. The owners are responsible for the property and administrative functions. They have owned the service for 13 years. They are supported by a clinical manager who is a registered nurse and has been employed by the service for 11 years.

The service has addressed six of the seven previous shortfalls from their last full certification audit and partial provisional audit around identifying a Maori consultant to review policies and procedures, analysing and trending quality data, updating the informed consent procedure, ensuring the GP signs the medication charts three-monthly, obtaining a certificate of public use and holding an approved fire evacuation plan. Further improvements continue to be required relating to landscaping of the external areas, and ensuring residents have access to shade and seating.

This audit identified improvements around the complaints register, reviewing a selection of policies and procedures, holding completed staff induction checklists, documenting a risk management plan, updating the hazard register, improving the documentation of service delivery, improving the documentation of individual activities plans; and improvements relating to the medicine management system.

## Audit Summary as at 5 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 5 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 low risk.
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### Organisational Management as at 5 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.		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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### Continuum of Service Delivery as at 5 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 5 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.		Some standards applicable to this service partially attained and of low risk.
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### **Restraint Minimisation and Safe Practice as at 5 November 2013**

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### **Infection Prevention and Control as at 5 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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# HealthCERT Aged Residential Care Audit Report (version 3.9)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Lexall Care Limited
<b>Certificate name:</b>	Lexall Care
<b>Designated Auditing Agency:</b>	HDANZ
<b>Types of audit:</b>	Surveillance
<b>Premises audited:</b>	Lexall Care, 19 Denver Ave, Sunnydale, Auckland
<b>Services audited:</b>	Rest home and hospital level care
<b>Dates of audit:</b>	<b>Start date:</b> 5 November 2013 <b>End date:</b> 5 November 2013
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	30

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	16	Total audit hours off site	12	Total audit hours	28
Number of residents interviewed	4	Number of staff interviewed	5	Number of managers interviewed	2
Number of residents' records reviewed	4	Number of staff records reviewed	4	Total number of managers (headcount)	2
Number of medication records reviewed	8	Total number of staff (headcount)	31	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	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, 18 December 2013

## Executive Summary of Audit

### General Overview

Lexall Care provides rest home and hospital level care for up to 58 residents. On the day of the audit, there were 24 residents in the rest home and six residents in the hospital. The owners are responsible for the property and administrative functions. They have owned the service for 13 years. They are supported by a clinical manager who is a registered nurse and has been employed by the service for 11 years.

The service has addressed six of the seven previous shortfalls from their last full certification audit and partial provisional audit around identifying a Maori consultant to review policies and procedures, analysing and trending quality data, updating the informed consent procedure, ensuring the GP signs the medication charts three-monthly, obtaining a certificate of public use and holding an approved fire evacuation plan.

Further improvements continue to be required relating to landscaping of the external areas, and ensuring residents have access to shade and seating.

The audit identified improvements around the complaints register, reviewing a selection of policies and procedures, holding completed staff induction checklists, documenting a risk management plan, updating the hazard register, improving the documentation of service delivery, improving the documentation of individual activities plans; and improvements relating to the medicine management system.

### Outcome 1.1: Consumer Rights

Families report they are kept informed of any change in the resident's status or of any adverse event. A complaints process is in place. There is evidence of follow-up actions taken for the complaints and concerns received, meeting the Health and Disability Commissioner's guidelines.

Improvements that have occurred since the last audit is the identification of a Maori consultant who is reviewing policies and procedures for the facility.

There is one required improvement around the complaints register.

### Outcome 1.2: Organisational Management

Quality goals are defined and are linked to the quality and risk management programme. Policies and procedures are held in hard copy and electronically. They are scheduled for two-yearly reviews. Data is collected, analysed and used for service improvements. Adverse events are documented and investigated by a registered nurse.

Processes are in place for the recruitment and selection of staff. Orientation is specific to the role and responsibilities of the position. Education and training programmes are in place.

Staffing for the facility meets contractual guidelines. A registered nurse is onsite 24 hours a day, seven days a week.

Improvements addressed from the previous audit include reviewing and analysing quality and risk data monthly and annually, and including detail relating to

health information in the informed consent form.

There are four required improvements. A selection of policies are due for review, evidence of implementation and sign off of corrective actions from internal audits is required, a risk management plan is required, and the hazard register requires review.

### **Outcome 1.3: Continuum of Service Delivery**

Residents are assessed on admission and a plan of care is developed in consultation with the resident, their family (where appropriate) and the resident's general practitioner. Service delivery is managed by a team of registered nurses who are in turn managed by a clinical nurse manager. The majority of the daily care is provided by a team of caregivers. There is a newly appointed activities coordinator who is responsible for the residents' individual and group activity programme. Residents are continually monitored and reviewed by staff. Residents are formally reviewed three monthly with the GP or earlier if the resident has a change in health status or is not medically stable. All residents are formally reviewed every six months by the nursing, medical and activities staff. Medicines are supplied from a contracted pharmacist and administered by registered nurses. The majority of food served is prepared on site by trained cooks in a purpose built kitchen and prepared according to a dietitian-approved menu. Residents and relatives who were spoken to are very satisfied with the care delivered and the standard of the food service.

Improvements that have occurred since the last audit include GP documentation.

A number of further improvements were identified which include: the documentation of service delivery, the documentation of individual activities plans; and improvements to the medicine management system.

### **Outcome 1.4: Safe and Appropriate Environment**

The facility is now spread over three levels. Only two levels were in use on the day of audit with the middle floor yet to be opened and occupied by residents. Finishing work was still in progress. The building has a current warrant of fitness, which expires 15 December 2013. The building warrant does not include the new alterations.

Improvements that have occurred since the last audit are: the new building alterations have been issued with a certificate of public use on 17 September 2013 up to 28 December 2013; and the fire evacuation plan has been approved on 23 July 2013.

The following previously identified improvements still need to be addressed: outside landscaping has yet to be completed and the plans for outside seating and tables have yet to be implemented.

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

Processes are in place to actively minimise the use of restraint. At the time of the audit, there were no residents using a restraint or an enabler.

### **Outcome 3: Infection Prevention and Control**

There is an established infection surveillance programme in place that is managed by the clinical manager. Surveillance data are collected monthly, graphed

and analysed for trends and results reported to staff through the quality and staff meetings.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	12	0	5	2	0	0
<b>Criteria</b>	0	33	0	9	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	31
<b>Criteria</b>	0	0	0	0	0	0	0	57

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	Written complaints are held separate to verbal complaints.	Ensure all complaints are documented in the complaints register.	180
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.2.3.3	The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Low	Policies are scheduled for two-yearly reviews although it is noted that a selection of policies have not been reviewed since 2009.	Ensure policies are regularly reviewed a minimum of two yearly, as determined by the service.	180
HDS(C)S.2008	Criterion 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.	PA Low	There is a lack of evidence to demonstrate that recommendations from internal audits are implemented and signed off.	Ensure recommendations from internal audit results are implemented and signed off when completed.	180
HDS(C)S.2008	Criterion 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.	PA Moderate	There is no risk management plan in place for the service. The hazard register was last reviewed in April 2012. The hazard register has not been updated since the 52 hospital beds were added to the service.	Ensure a risk management plan is in place. The hazard register required updating to reflect new hazards identified since the addition of 52 hospital level beds.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Evidence of completed induction checklists were not available for sighting in the caregiver staff files although two care givers, the clinical manager and one RN report an induction checklist is in place.	Ensure evidence of completed induction checklists are held by the service.	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 Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Service provision documentation is not always completed in a timely manner and not signed and dated making it not possible to determine that service provision is documented and provided within appropriate time frames, as specified in the ARC agreement.	All staff need to complete documentation in a timely manner and include day, date and month on records so that there is a record of care provision.	30
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Five newly admitted residents have yet to be formally assessed by the recently appointed activities coordinator and an individual social and recreational programme developed.	Ensure all new admissions are formally assessed by the activities coordinator and a written and implemented social and recreational programme is developed that meets each resident's identified interests, stated preferences and level of ability/disability.	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
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 Moderate	The medicine management system in use is not consistent with the medicine care guides for residential aged care in the following areas. Dated resident identification photos were not included in all files. Standing orders in use do not meet Ministry of Health guidelines.	Ensure the medicine system in use fully complies with the medicine care guides for residential aged care.	30

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	One resident who was admitted for respite care and who was self-administering some of her medicines was not managed according to the guidelines in that medicines were administered to her without a prescriber's order; there was no medicine reconciliation on admission, there was no capacity assessment of her cognitive and physical ability conducted and signed off by the regular prescriber prior to her self-administering her medicines and she also had no dated identification photo on file. She was discharged on the day of audit.	Ensure residents who self-administer medicines do so in a manner consistent with the medicine care guides for residential aged care.	30
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 Low	PRN medicines are not always correctly charted by the prescriber consistent with the requirements specified in the medicine care guides for residential aged care.	Ensure PRN medicines are charted correctly by the prescribing practitioner.	60
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	Ensure outside areas are fully landscaped and that residents have access to shade and outdoor seating.	Complete the landscaping plan.	60

## Continuous Improvement (CI) Report

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>

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

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## Outcome 1.1: Consumer Rights

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

### **Standard 1.1.1: 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

### **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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 1.1.2: 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:** Not Audited

**Evidence:**

### 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:** Not Audited

**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:** Not Audited

**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:** Not Audited

**Evidence:**

#### 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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Links with Maori health authorities are in place. A Maori health officer to the Waitemata District Health Board is currently reviewing the service's policies and procedures to ensure that they meet the needs of Maori. This is an improvement from the last certification audit on 30 April 2012.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.1.6: 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

ARHSS D16.5e

**Attainment and Risk:** Not Audited

**Evidence:**

### **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:** Not Audited

**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:** Not Audited

**Evidence:**

### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.1.9: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is an open disclosure policy, a complaints policy and an incident/accident reporting policy.</p> <p>Four residents (two rest home, two hospital) and four relatives (one rest home, three hospital) report they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur on a quarterly basis (meeting minutes sighted).</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>D16.4b The four family members (one rest home, three hospital) interviewed stated that they are informed when their family member's health status changes or of any other issues arising. Evidence of families being notified was also evidenced in three of three accident/incident forms where an injury had been sustained.</p>

**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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

**Standard 1.1.10: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The informed consent form that is signed by the resident or their family/EPOA provides written consent for permission to collect and store information and indemnity and outing consent. Evidence of consent was documented in all four clinical records audited. The informed consent procedure has been updated. This is an improvement

from the previous certification audit (30 April 2012) (reference 1.2.9.5).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.1.11: 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 1.1.12: 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:** Not Audited

**Evidence:**

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau.

Four residents (two rest home, two hospital) and four relatives (one rest home, three hospital) confirm they are aware of the complaints process and they would make a complaint to the clinical manager if necessary.

There is a complaints register that holds evidence of one complaint lodged in 2012 and no complaints lodged in 2013. All documentation including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder.

The clinical manager reports she was under the impression that only written complaints are logged in the complaints register. Verbal complaints are being lodged in the 'corrective actions' folder. For 2013, there are eight verbal complaints lodged in the corrective actions folder with evidence of six of the complaints being resolved and two of the complaints on-going. There is evidence to support these verbal complaints are being managed in a timely manner as per the HDC guidelines.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a complaints register that holds evidence of one complaint lodged in 2012 and no complaints lodged in 2013. All documentation including acknowledgement letters, investigation reports and follow up letters is maintained in the complaints folder.

The clinical manager reports she was under the impression that only written complaints are logged in the complaints register. Verbal complaints are being lodged in the 'corrective actions' folder. For 2013, there are eight verbal complaints lodged in the corrective actions folder with evidence of six of the complaints being resolved and two of the complaints on-going. There is evidence to support these complaints are being managed in a timely manner as per the HDC guidelines.

**Finding:**

Written complaints are held separate to verbal complaints.

**Corrective Action:**

Ensure all complaints are documented in the complaints register.

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Lexall Care is a 58 bed privately owned aged care facility located in West Auckland. On the day of this spot surveillance audit, there were 24 rest home level residents and six hospital-level residents. Fifty-two hospital rooms have recently been added to the facility. At the time of the audit, the service was working towards filling the hospital level beds.

The long-term goals of the service are: to provide a high standard of team work and co-operation between staff; to have the best reputation in the local community; the development of a high standard of care and achieving full occupancy.

There are two Korean owners/managers who have owned the facility for 13 years. They work on site Monday to Friday. One owner has experience in finance and business and is designated as the maintenance staff member. He has a Bachelor's Degree in Property Management (New Zealand) and a Master's Degree in Finance and Accounting (Sydney). The other owner/manager has completed a Certificate in Aged Care and a Certificate in Management (St Johns) and completes on-going education annually for at least eight hours a year through the Aged Care Association. Professional development in 2013 includes attendance at the CANZ Professional Development Day (eight hours) and attendance at an Employment Law seminar (two hours). They have owned the service for 12 years and have been 'hands on' in the service during this period.

A registered nurse is appointed as the clinical manager. She has been employed by the service for 11 years. The clinical manager has a post-graduate certificate in health sciences with a focus in palliative care. She has qualified through Waikato District Health Board (WDHB) as a preceptor for new graduate registered nurses and completes on-going training throughout the year with WDHB. She holds a current practicing certificate and current first aid/CPR certificate.

**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.

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

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

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 1.2.3: 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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Quality (short-term) goals, defined by the owners include: effective and prompt care services; the best quality and rich minimisation in care and management; staff with a good standard of education; family atmosphere where staff and residents feel involved in decision-making; good cooperation and communication between residents, staff, management and the community. These goals are clearly understood by the clinical manager who is responsible for the oversight of the quality and risk management programmes. Policies and procedures are held electronically and in hard copy. The most recent review date is reflected in the footer of each policy. Policies are scheduled for two-yearly reviews although it is noted that a selection of policies have not been reviewed since 2009. The document control system lists new policies and policies that have

been revised, evidenced in a face sheet in each policy manual. The clinical manager reports updates to policies are also discussed in quarterly quality assurance meetings.

The collection of data includes complaints (verbal and written), incidents and accidents, hazards, infections, the use of restraints and enablers, internal audit results, education and training, and any other issues or initiatives that are identified as opportunities for improvements. The internal audit programme involves the monitoring of various aspects of the service including for 2013: cleaning; safety; resident cares; building compliance; medication, restraint, food, lifting, disturbing behaviour, admission, privacy, infection control, care plans.

Quality improvement data are collected, analysed and evaluated. This includes monthly reports and annual reports. This is an improvement from the previous certification audit (30 Apr 2012). The clinical manager is responsible for ensuring all internal audits are completed according to the audit schedule. Results of the internal audits are communicated to staff (evidenced in the quality assurance (QA) quarterly meeting minutes). A system for analyses of collected data (eg, health and safety, complaints, infections, accidents/incidents and infection control) is in place.

Recommendations and corrective actions are documented where opportunities for improvements are noted in the data that is collected. There is a lack of evidence to demonstrate that recommendations from internal audits are implemented and signed off.

Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The hazard register was last reviewed in April 2012. The hazard register has not been updated since the 52 hospital beds were added to the service. Risks and hazards are monitored through the internal audit programme.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Policies and procedures are held electronically and in hard copy. The most recent review date is reflected in the footer of each policy. Policies are scheduled for two-yearly reviews although it is noted that a selection of policies have not been reviewed since 2009. The document control system lists new policies and policies that have

been revised, evidenced in a face sheet in each policy manual. The clinical manager reports updates to policies are also discussed in quarterly quality assurance meetings.

**Finding:**

Policies are scheduled for two-yearly reviews although it is noted that a selection of policies have not been reviewed since 2009.

**Corrective Action:**

Ensure policies are regularly reviewed a minimum of two yearly, as determined by the service.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Recommendations and corrective actions are put into place where opportunities for improvements are noted in the data that is collected. There is a lack of evidence to

demonstrate that recommendations from internal audits are implemented and signed off.

**Finding:**

There is a lack of evidence to demonstrate that recommendations from internal audits are implemented and signed off.

**Corrective Action:**

Ensure recommendations from internal audit results are implemented and signed off when completed.

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** PA Moderate

**Evidence:**

The owners and clinical manager were unable to locate a risk management plan for the facility. Hazards that are identified in the hazard register were last reviewed in April 2012. The hazard register has not been updated since the 52 hospital beds were added to the service. Risks and hazards are monitored through the internal audit programme.

**Finding:**

There is no risk management plan in place for the service. The hazard register was last reviewed in April 2012. The hazard register has not been updated since the 52 hospital beds were added to the service.

**Corrective Action:**

Ensure a risk management plan is in place. The hazard register required updating to reflect new hazards identified since the addition of 52 hospital level beds.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Statutory and regulatory obligations are understood by the clinical manager. Examples include notification to the appropriate authorities (eg, Occupational Health and

Safety (OSH), Waitemata District Health Board, Ministry of Health) in regards to serious injuries, coroner's inquests, changes in management and complaints lodged with the Health and Disability Commissioner.  
Adverse events (eg, falls, skin tears, medicine management errors) are documented on incident and accident forms. Twelve forms were randomly selected for audit. There is evidence of an registered nurse (RN) investigation and sign-off for each event lodged. The number of events are collected each month with evidence of feedback to staff (reference 1.2.3).

**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.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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:** PA Low

**Evidence:**

Annual practising certificates, which include scope of practice, are validated with copies of certificates held in each health professional's personnel file. All six registered nurses practising certificates sighted are current. Evidence of practising certificates were also sighted for the GP and podiatrist. Plans are underway to provide physiotherapy and occupational therapy services.

There are employment guidelines and templates, which include an application form, interview questionnaire, reference check forms and standard letter for employment. Four staff files were randomly selected for audit (one clinical manager, one RN, and two senior caregivers). Employment agreements were sighted in three of the four employee files. Staff sign their position description as part of the orientation process. The clinical manager has completed her preceptor course with Waitemata DHB and is able to support new graduates in the service. Of the five recently employed registered nurses, there are three new graduates and two experienced registered nurses in hospital/rest home care. New graduate registered nurses plan to attend the WDHB new graduate training programme.

Orientation of caregivers is completed using a buddy system with support and oversight from the clinical manager. Evidence of completed induction checklists were not available for sighting in the caregiver staff files although two care givers, the clinical manager and one RN report an induction checklist is in place.

There are implemented competencies for staff related to specialised procedure or treatment including medication, infection control, evacuation scheme, health and safety, care of sharps, hygiene and personal care, skin care and skin integrity.

The 2012 education and training programme sighted includes promoting continence (attendance 7 (63%); privacy (6); cultural safety (8); restraint (8); consent and advance directives (9); code of rights (12); abuse/neglect (6); medication management (5); health and safety (8); sex/intimacy (6); documentation (10); emergency training (12); open disclosure (9); manual handling (8) Annual performance appraisals are up-to-date. The 2013 education and training programme completed year-to-date includes emergency procedures (13); medication management (3); falls prevention (13); end of life care (10). Six monthly fire evacuation training and first aid/CPR training is in place for staff. Plans are in place to implement an on-line education and training programme for staff.

### 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.

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Orientation of caregivers is completed using a buddy system with support and oversight from the clinical manager. Evidence of completed induction checklists were not available for sighting in the caregiver staff files although two care givers, the clinical manager and one RN report an induction checklist is in place.
<b>Finding:</b> Evidence of completed induction checklists were not available for sighting in the caregiver staff files although two care givers, the clinical manager and one RN report an induction checklist is in place.
<b>Corrective Action:</b> Ensure evidence of completed induction checklists are held by the service.
<b>Timeframe (days):</b> 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

**Standard 1.2.8: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has recently employed six registered nurses. Additional RN staffing will be employed as the number of occupied hospital beds increases. At present, the following staffing rationale is in place for an occupancy of 30 beds (24 rest home level and six hospital level).  AM: Two RNs (one clinical manager and one staff RN) Monday – Friday with one RN on the weekends and three caregiver staff.  PM: One RN and three caregivers  Night shift: One RN and one caregiver.  Separate staff are employed for cleaning and laundry services.  Four residents (two rest home, two hospital) and four relatives (one rest home, three hospital) confirm staff are available to meet their needs.</p>

**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.

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

## Standard 1.2.9: 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:** Not Audited

**Evidence:**

### 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:** Not Audited

**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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

All records pertaining to individual consumer service delivery are integrated.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## 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:** Not Audited

**Evidence:**

### 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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** Not Audited

**Evidence:**

### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Service delivery policies are in place to guide practice. Assessment, planning, provision and evaluation of all aspects of the service are managed by registered nurses in collaboration with a general practitioner, the activities coordinators and caregivers. External specialists are used to assist. All admissions, clinical assessments and care planning are developed and evaluated by a registered nurse (confirmed by review of four of four clinical records (two hospital and two rest home residents). When residents are admitted, they are assessed by the general practitioner within 48 hours of admission.  Tracer Hospital XXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i>  Tracer Rest home XXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i>  Documentation is not completed and signed off and dated making it not possible to track the timeliness of care provision and the staff member involved (refer 1.3.3.3).

**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.

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> D16.2 Residents have an initial assessment within 24 hours of admission, which covers a range of aspects including their physical, psycho-social, and cultural values and beliefs. They are seen by a general practitioner within 48 hours of admission. Long term care plans are implemented. Two rest home (one respite and one long term resident) and two hospital resident's records were reviewed. One of the two rest home resident's admission nursing summary plan was dated but not signed and one of the two hospital residents did not have a long term care plan in place within three weeks of admission. Staff are documenting care but are not always completing documentation in a timely manner and not dating these records.
<b>Finding:</b> Service provision documentation is not always completed in a timely manner and not signed and dated making it not possible to determine that service provision is documented and provided within appropriate time frames, as specified in the ARC agreement.
<b>Corrective Action:</b> All staff need to complete documentation in a timely manner and include day, date and month on records so that there is a record of care provision.
<b>Timeframe (days):</b> 30 (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.

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

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** Not Audited

**Evidence:**

### 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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** Not Audited

**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:**

Policies that support service delivery are in place. Residents are provided with services, which match their assessed needs. Service delivery is overseen by RNs and documented in plans of care. Each shift of care staff report against progress verbally in the handover between shifts and document progress in the resident's clinical records. There are three residents who have wounds currently (one has a grade one pressure area which is improving; the second resident is under the care of the wound nurse specialist Waitakere Hospital and the third resident was admitted with a pre-existing wound above her eye). All wounds have a management plan in place. Residents have access to continence products as needed. Service delivery is reviewed three monthly by RNs and the GP or is reviewed more frequently if the resident is considered not medically stable (confirmed in discussions with four of four residents (two rest home and two hospital), four of four relatives (three hospital and one rest home), 1 clinical manager (who is a registered nurse (RN)), one RN, two of two caregivers, one general practitioner, one visiting psychiatrist and one RN mental health nurse specialist and confirmed in review of four of four clinical records (two hospital and two rest home). The general practitioner was interviewed. He reported that he is pleased with the standard of clinical information he receives from the clinical manager and the newly appointed registered nurses and the standard of care provided.

#### 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:** PA Low

**Evidence:**

The activities programme is run by one activities coordinator who commenced employment on 7 October 2013 (replacing the other activities coordinator who retired). The activities coordinator has a background in the role in a previous facility but has not had formal training as yet. The owners intention is that formal diversional therapy training will be arranged. Currently the activities coordinator is employed Monday to Wednesday from 9.30 am to 2 pm, which is an increase of two hours a day from the previous activities coordinator. The group programme is mostly provided in the café lounge by the activities coordinator and is attended by both rest home and hospital level residents. There are other locations throughout the building where group activities may be offered (eg, separate lounge areas and the dining room). The intention of policy is that each resident has an activities assessment on admission and then an individual plan of activities is developed and implemented according to the resident's wishes. A record of involvement in activities is kept and the activities coordinator is involved in on-going care review.

Five recent admissions have yet to be formally assessed. The activities coordinator has requested additional hours so that she can run both the group programme and complete her assessment and planning commitments. The owner intends to increase the activities coordinator's hours when occupancy increases.

The activities schedule was viewed and included the following types of activities: exercises, walks, indoor bowls, and discussions with each other and on current events, bingo, quizzes. Resident's birthdays are celebrated and every Friday up to six residents go for a drive in a taxi van. A Maori cultural group provide a church service and play guitars every Tuesday following their session. There is a group of Korean women who come once a week on the weekend from a local church. A number of residents identify as Korean and these residents enjoy this visit. The activities coordinator intends to revise and extend the group activities programme in the near future.

#### 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:** PA Low

**Evidence:**

Five newly admitted residents have yet to be formally assessed and have a written individual activities programme (D16.5). The lack of an individual activities plan may be contributing to the level of depression being experienced by one hospital level resident . The activities coordinator has taken action to introduce this resident to a group of Maori entertainers, which was very successful and much appreciated by the resident who identifies as Maori.

**Finding:**

Five newly admitted residents have yet to be formally assessed by the recently appointed activities coordinator and an individual social and recreational programme developed.

**Corrective Action:**

Ensure all new admissions are formally assessed by the activities coordinator and a written and implemented social and recreational programme is developed that meets each resident's identified interests, stated preferences and level of ability/disability.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Regular evaluation of service delivery plans occur commencing in the initial few weeks of admission. Progress notes are recorded on each shift for all residents. Monitoring of a residents progress occurs and is an on-going process. Registered nurses reassess and evaluate residents whenever there are changes to their health or when residents, staff or relatives have concerns. Each resident has a formal evaluation on a six monthly basis and family are invited to attend. Care plans are updated to reflect current goals. Medical reviews meet contract requirements.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

**Standard 1.3.9: 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.3.10: 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:** Not Audited

**Evidence:**

#### 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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

A review of eight medicine management charts and systems in use was conducted (which included the four residents reviewed in the sample and another four residents making a stratified sample of four hospital and four rest home). The review found that the medicine management system in use is outlined in policy. Medicines are supplied every four weeks from a contracted pharmacist. Tablets are dispensed in blister packaging. Other medicines are dispensed in containers with pharmacy labels. Medicines are stored in a locked cupboard in a medicines room when not in use. Controlled drugs are stored in a locked cabinet that complies with the drug regulations (the owners have yet to install a new controlled drugs cabinet, which is a larger size). A stocktake is done weekly on controlled drugs and recorded (a stocktake on the day of audit showed that balances were correct). The administration of medicines was observed and practice was appropriate. Competencies are completed by staff. Seven of eight residents had a medicine orders chart signed by a prescribing GP, which were legible and included a statement regarding their allergy status. The eighth

resident had no medicine chart on file yet staff were administering medicines. Only two of the eight residents in the sample had a dated identification photograph on file. Three of the eight residents charts contained evidence of three monthly reviews by the GP. Four other residents had not been admitted for three months (and the eight had no chart). The charting of PRN orders was not consistent with the medicine care guides for residential aged care in that the indication and instructions for PRN use are not always specified.

The facility is using standing orders that do not comply with the standing order guidelines as published by the Ministry of Health.

The facility is using hospital imprest stock for rest home residents, which is not consistent with the guidelines for bulk supply, which applies to hospital certified facilities only.

The rest home resident admitted for respite care was self-administering some of her medicines. The review showed that there was no confirmation with her GP on admission regarding her medicines. There was no evidence of a medicine reconciliation occurring on admission. There was no medicine chart completed to specify medicine orders for staff to administer medicines. There was no capacity assessment to assess cognitive and physical ability to self-medicate signed off by the regular prescriber prior to her self-medicating and no dated photo identification on file.

D16.5.e.i.2; Three of the eight residents charts contained evidence of three monthly reviews by the GP and the GP had documented the review and their stability in their clinical records (The other residents had been admitted recently). This is an improvement since the previous audit.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The medicine system in use for eight residents was reviewed. One of eight residents had no medicine order chart signed by a prescribing GP yet staff were administering medicines. Only two of the eight residents in the sample had a dated identification photograph on file. The facility is using standing orders that do not comply with the standing order guidelines, as published by the Ministry of Health. The facility is using hospital imprest stock for rest home residents, which is not consistent with the guidelines for bulk supply, which applies to hospital certified facilities only.

**Finding:**

The medicine management system in use is not consistent with the medicine care guides for residential aged care in the following areas. Dated resident identification photos were not included in all files. Standing orders in use do not meet Ministry of Health guidelines.

**Corrective Action:**

Ensure the medicine system in use fully complies with the medicine care guides for residential aged care.

**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.

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> One rest home resident admitted for respite care was self-administering some of her medicines. There was no confirmation with her GP on admission regarding her medicines. There was no evidence of a medicine reconciliation occurring on admission. There was no medicine chart completed to specify medicine orders for staff to administer medicines. There was no capacity assessment to assess cognitive and physical ability to self-medicate signed off by the regular prescriber prior to her self-medicating and no dated photo identification on file. The resident was discharged on the day of audit.
<b>Finding:</b> One resident who was admitted for respite care and who was self-administering some of her medicines was not managed according to the guidelines in that medicines were administered to her without a prescriber's order; there was no medicine reconciliation on admission, there was no capacity assessment of her cognitive and physical ability conducted and signed off by the regular prescriber prior to her self-administering her medicines and she also had no dated identification photo on file. She was discharged on the day of audit.
<b>Corrective Action:</b> Ensure residents who self-administer medicines do so in a manner consistent with the medicine care guides for residential aged care.
<b>Timeframe (days):</b> 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The charting of PRN orders in a sample of four of eight medicine charts reviewed is not always consistent with the medicine care guides for residential aged care in that the indication and instructions for PRN use are not always specified. The sample was extended and the practice is systemic. No evidence of harm to a resident was sighted.
<b>Finding:</b> PRN medicines are not always correctly charted by the prescriber consistent with the requirements specified in the medicine care guides for residential aged care.
<b>Corrective Action:</b> Ensure PRN medicines are charted correctly by the prescribing practitioner.
<b>Timeframe (days):</b> 60 (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is a kitchen onsite, which was recently refurbished. There is a mixture of commercial grade and domestic grade appliances and equipment available. Food can be cooked on gas hobs or by electricity in the combi oven. The kitchen is clean and tidy. There are dedicated staff to prepare meals. There are three main cooks employed who work a mix of hours from 7 am to 4.30 pm. Menus have been reviewed by a registered dietitian (last review March 2013). There is change of menus with rotations by weeks. The core diet meets the nutritional needs of the consumers. Modified diets for reasons of need or preference are catered for. The cooks cater for Korean, halal food and other dietary needs currently. The service has lipped plates, sipper cups and other built up utensils available. Resident likes, dislikes, allergies and dietary needs are kept in a folder in the kitchen and kitchen staff are familiar with the folder and contents. Food is procured from and supplied by commercial contracted companies. The majority of food is prepared on site and served in the dining room, which is close to the kitchen. There is another dining room on another floor that has yet to be opened due to low occupancy. Food storage is appropriate. The cooks have access to dry storage, refrigeration and a freezer. The temperatures of the refrigerator and freezer are monitored daily and the temperature of cooked food is monitored. Temperatures are within appropriate ranges. Food waste is disposed of by a contractor. Residents and relatives enjoy the food served (residents meal service observed on day of audit and confirmed in discussions with four of four residents (two rest home and two hospital residents) and four of four relatives (one rest home and three hospital)).  D19.2 The cooks have been trained in safe food handling -

**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.

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

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

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

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

**Criterion 1.3.13.5 (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.

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

**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:** Not Audited

**Evidence:**

#### **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:** Not Audited

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.4.2: 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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b>
<p>The building has a current warrant of fitness issued on 15 December 2012 expires 15 December 2013 which does not include the current new building alterations. The new building has been issued with a certificate of public use on 17 September 2013 up to 28 December 2013 (certificate sighted). This is an improvement since the previous partial provisional audit.</p> <p>The new building is on three levels. Only two levels were in use on the day of audit with the middle floor yet to be opened and occupied by residents. Finishing work was still in progress.</p> <p>The partial provisional audit identified that the garden areas had yet to be landscaped and the plans for outside seating and tables had yet to be implemented. This remains an improvement from the previous audit (refer 1.4.2.6).</p>

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

All buildings, plant, and equipment comply with legislation.

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

**Criterion 1.4.2.4 (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.

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Garden areas have not yet been fully landscaped outside the back of the property, which is accessed by residents on the lower floor. There are plans for outside seating and tables and these have yet to be implemented as the owners have been waiting for a change in weather.

<b>Finding:</b> Ensure outside areas are fully landscaped and that residents have access to shade and outdoor seating.
<b>Corrective Action:</b> Complete the landscaping plan.
<b>Timeframe (days):</b> 60 (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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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:** Not Audited

**Evidence:**

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

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

**Attainment and Risk:** Not Audited

**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:** Not Audited

**Evidence:**

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.4.7: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  The partial provisional audit identified that the fire evacuation plan had yet to be approved. The fire evacuation plan was approved on 23 July 2013. This is an improvement from the previous audit.

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.4.8: 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.8.2 (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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Processes are in place to actively minimise the use of restraint. Policies identify alternative strategies, approved methods of restraint, risk assessment, monitoring and the restraint evaluation process. At the time of the audit, there were no residents using a restraint or an enabler.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

#### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

#### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Services evaluate all episodes of restraint.

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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### 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

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

**Standard 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

**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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

#### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

### 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Criterion 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.

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Surveillance procedures are in place and specified in the infection prevention and control programme. Infections are determined using definitions. Surveillance data are collected monthly, graphed and analysed for trends and reported through the quality/ staff meeting and back to staff. Data includes all infections and not just those treated

with antibiotics. Infection control management is part of the organisation's quality and risk management system. There are policies and procedures in place to minimise the risk of infection to consumers, service providers and visitors. All staff are involved in infection prevention and control practices. The clinical manager who has training and experience in infection control is the designated infection prevention and control coordinator. An annual review of the infection control programme has been last completed in January 2013. There is a three monthly staff (QA) meeting with infection prevention and control as an agenda item and monthly meetings with staff where infection prevention and control practices are discussed.

**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.

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

**Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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