

# Shoal Bay Villa Limited

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Current Status: 25 November 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit and Verification 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

Shoal Bay Villa is a privately owned facility. Currently it offers rest home level care to 26 residents. On the day of audit there are 25 residents. All services are overseen by the registered nurse (RN) manager who has owned the facility since 2007.

This audit is also a verification audit to look at the service compliance with relevant standards to offer secure dementia care for all 26 beds.

There are five areas identified as requiring improvement. These relate to actual and potential risk management for running the service during the transition from rest home to secure dementia care; staff designation which is not always being shown in progress notes; the three week timeframe for long term care planning which is not always met; the kitchen does not meet all infection prevention requirements; and environmental upgrades are not completed to ensure safe resident management during the transition of services.

## Audit Summary as at 25 November 2013

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 25 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.		Standards applicable to this service fully attained.
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### Organisational Management as at 25 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 low risk.
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### Continuum of Service Delivery as at 25 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 low risk.
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### Safe and Appropriate Environment as at 25 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 25 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 25 November 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 25 November 2013

### Consumer Rights

The residents and family/whanau interviewed express satisfaction with the manner in which the service respects their rights and report that they are treated with respect and dignity and are free from discrimination. As observed at the onsite audit, residents receive services that uphold their rights. Staff demonstrate understanding of their obligations regarding residents' rights and how to incorporate that knowledge into their day-to-day practices and interactions with residents and family/whānau.

The service meets the individual resident's culture, beliefs and values, including for those residents who identify as Maori.

Evidence-based practice is observed, promoting and encouraging good practice. There is regular in-service education and staff access external education that is focused on aged care and best practice. The residents and family/whānau interviewed expressed high satisfaction with the care delivered.

The service acknowledges that all residents have a right to full and frank information as identified in the open disclosure policy. An interpreter service is accessed through the district health board as required. Written consent is gained as appropriate. Staff interviewed acknowledge the resident's right to make choices based on information presented to them and the right to withdraw consent and/or refuse treatment. Advance directives and advance care planning are made available and acted upon where valid.

There is a documented complaints process which is implemented to ensure all complaints are followed up and information is used as an opportunity to improve service delivery as appropriate. At the time of audit there are no outstanding complaints.

### Organisational Management

The organisation has had a recent name change. It was known as Big Guys Limited and is now Shoal Bay Villa Limited. There have been no governance changes and remains a sole ownership privately owned facility.

The organisation's purpose, values, and mission statement are identified in the business plan, which is the document that identifies how services are planned and coordinated to meet residents'

needs. The quality and risk plan shows the measures taken to deliver services in a safe and effective manner. Deficits to service delivery are managed through corrective action planning as appropriate.

An area identified for improvement relates to the need for transitional planning process (from rest home level care to secure dementia care) to be identified in detail and to meet DHB contractual and portfolio manager requirements and to ensure all staff include their designation when writing in clinical documentation.

Quality is reviewed and measured via the internal audit schedule, complaints management, satisfaction survey results, data collation and review, and staff and family/whanau meetings. All quality and risk activities are monitored by the RN manager and used as an opportunity to improve services, wherever possible.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whanau interviews and in the 2013 satisfaction survey results.

The service implements safe staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and that legislative requirements are met. Staff members' knowledge and skills are maintained through on-going education which is appropriate to their role. Staff education offered includes specific dementia care qualifications.

The resident information is stored in a safe and secure manner. Archived records are easily retrievable. There is an area requiring improvement to ensure the staff consistently record their designation in the progress notes.

### **Continuum of Service Delivery**

Services are provided by suitably qualified and trained staff to meet the needs of residents. The service is increasing education and training related to specialist dementia care in preparation for the service providing this type of care.

The service has systems in place to assess, plan, review and evaluate the care needs of each resident. Residents have an initial nursing assessment and care plan developed by the enrolled nurse (EN), and authorised by the registered nurse (RN), on admission to the service. The service meets the contractual times frames for the review and evaluation of the care plan. There is an improvement required to ensure the long term care plan is developed within three weeks of the resident's admission.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently, to respond to any changing needs. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided to ensure the continuity of services. Referrals to other health and disability services are planned and co-ordinated as required, based on the individual needs of the resident.

The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to maintain links with family and the community.

A safe and timely medicine management system is observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent.

Residents' nutritional requirements are met by the service. As confirmed during interviews with residents and family/whānau, likes, dislikes and special diets are well catered for. The service has a four week menu with seasonal variations which has been approved by a registered dietitian.

### **Safe and Appropriate Environment**

Shoal Bay Villa Rest Home has documented emergency response processes which are understood and implemented by the service as required. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. Fire evacuations and emergency education is undertaken as part of orientation for new staff and ongoing education. The building has a current warrant of fitness and the service has an approved fire evacuation plan.

The facilities are suitable for rest home level care and work is well underway to ensure it will also be safe for secure dementia care. An improvement is required related to the level of detail shown in the transition plan. It does not detail how the overall environment will be managed when both rest home level care and dementia care services will run concurrently. The external environment upgrades need to be completed.

Furnishings and equipment are appropriately maintained to meet residents' needs. All bedrooms are single occupancy, eight have toilet ensembles and all bedrooms have hand washing facilities. Shower areas are centrally located. The dining and lounge areas meet residents' relaxation, activity and dining needs. This includes a small quiet lounge area.

The facility is appropriately heated and ventilated through opening doors and windows. There are upgraded outdoor areas that have seating and are sheltered for residents' use.

### **Restraint Minimisation and Safe Practice**

The service has a lock on the two main exit doors. This is identified in policies and procedures as being for safety reasons and is discussed and consented to by residents and family/whānau upon entry to the service. It is not a selected restraint process but a safety and security measure. The access code is available to all family/whānau.

Currently resident access is limited to some outdoor areas owing to construction work. This is documented as environmental enablers and will cease when the building work is complete. Policy clearly describes enablers as voluntary and the least restrictive option.

### **Infection Prevention and Control**

The service has an appropriate infection prevention and control management system that is developed and reviewed by an infection control advisory service. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. The

infection control programme is reviewed annually. The organisation's infection prevention and control policies and procedures reflect current accepted good practice. Relevant education is provided for both staff and residents. The monthly infection surveillance data is analysed, and where trends are identified, actions are implemented to reduce infections.

# 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>	Shoal Bay Villa Ltd
<b>Certificate name:</b>	Shoal Bay Villa Rest Home
<b>Designated Auditing Agency:</b>	DAA Group
<b>Types of audit:</b>	Certification and Verification
<b>Premises audited:</b>	33 Church Street, Northcote, Auckland
<b>Services audited:</b>	Rest Home
<b>Dates of audit:</b>	<b>Start date:</b> 25 November 2013 <b>End date:</b> 26 November 2013
<b>Proposed changes to current services (if any):</b>	
	The service wishes to transfer all 26 rest home level care beds to secure dementia care.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	25

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	16	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	16	<b>Total hours off site</b>	8
<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>	3

## Sample Totals

Total audit hours on site	32	Total audit hours off site	19	Total audit hours	51
Number of residents interviewed	6	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	15	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	

## Declaration

I, XXXXX, of 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	
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	
d)	this audit report has been approved by the lead auditor named above	
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	
g)	the DAA has provided all the information that is relevant to the audit	
h)	the DAA Auditing Agency has finished editing the document.	

Dated

## Executive Summary of Audit

### General Overview

Shoal Bay Villa is a privately owned facility. Currently it offers rest home level care to 26 residents. On the day of audit there are 25 residents. All services are overseen by the registered nurse (RN) manager who has owned the facility since 2007.

This audit is also a verification audit to look at the service compliance with relevant standards to offer secure dementia care for all 26 beds.

There are five areas identified as requiring improvement. These relate to actual and potential risk management for running the service during the transition from rest home to secure dementia care; staff designation which is not always being shown in progress notes; the three week timeframe for long term care planning which is not always met; the kitchen does not meet all infection prevention requirements; and environmental upgrades are not completed to ensure safe resident management during the transition of services.

### Outcome 1.1: Consumer Rights

The residents and family/whanau interviewed express satisfaction with the manner in which the service respects their rights and report that they are treated with respect and dignity and are free from discrimination. As observed at the onsite audit, residents receive services that uphold their rights. Staff demonstrate understanding of their obligations regarding residents' rights and how to incorporate that knowledge into their day-to-day practices and interactions with residents and family/whānau.

The service meets the individual resident's culture, beliefs and values, including for those residents who identify as Maori.

Evidence-based practice is observed, promoting and encouraging good practice. There is regular in-service education and staff access external education that is focused on aged care and best practice. The residents and family/whānau interviewed expressed high satisfaction with the care delivered.

The service acknowledges that all residents have a right to full and frank information as identified in the open disclosure policy. An interpreter service is accessed through the district health board as required. Written consent is gained as appropriate. Staff interviewed acknowledge the resident's right to make choices based on information presented to them and the right to withdraw consent and/or refuse treatment. Advance directives and advance care planning are made available and acted upon where valid.

There is a documented complaints process which is implemented to ensure all complaints are followed up and information is used as an opportunity to improve service delivery as appropriate. At the time of audit there are no outstanding complaints.

### Outcome 1.2: Organisational Management

The organisation has had a recent name change. It was known as Big Guys Limited and is now Shoal Bay Villa Limited. There have been no governance

changes and remains a sole ownership privately owned facility.

The organisation's purpose, values, and mission statement are identified in the business plan, which is the document that identifies how services are planned and coordinated to meet residents' needs. The quality and risk plan shows the measures taken to deliver services in a safe and effective manner. Deficits to service delivery are managed through corrective action planning as appropriate.

An area identified for improvement relates to the need for transitional planning process (from rest home level care to secure dementia care) to be identified in detail and to meet DHB contractual and portfolio manager requirements and to ensure all staff include their designation when writing in clinical documentation.

Quality is reviewed and measured via the internal audit schedule, complaints management, satisfaction survey results, data collation and review, and staff and family/whanau meetings. All quality and risk activities are monitored by the RN manager and used as an opportunity to improve services, wherever possible.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whanau interviews and in the 2013 satisfaction survey results.

The service implements safe staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and that legislative requirements are met. Staff members' knowledge and skills are maintained through on-going education which is appropriate to their role. Staff education offered includes specific dementia care qualifications.

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

Services are provided by suitably qualified and trained staff to meet the needs of residents. The service is increasing education and training related to specialist dementia care in preparation for the service providing this type of care.

The service has systems in place to assess, plan, review and evaluate the care needs of each resident. Residents have an initial nursing assessment and care plan developed by the enrolled nurse (EN), and authorised by the registered nurse (RN), on admission to the service. The service meets the contractual times frames for the review and evaluation of the care plan. There is an improvement required to ensure the long term care plan is developed within three weeks of the resident's admission.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently, to respond to any changing needs. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided to ensure the continuity of services. Referrals to other health and disability services are planned and co-ordinated as required, based on the individual needs of the resident.

The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to maintain links with family and

the community.

A safe and timely medicine management system is observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent.

Residents' nutritional requirements are met by the service. As confirmed during interviews with residents and family/whānau, likes, dislikes and special diets are well catered for. The service has a four week menu with seasonal variations which has been approved by a registered dietitian.

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

Shoal Bay Villa Rest Home has documented emergency response processes which are understood and implemented by the service as required. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. Fire evacuations and emergency education is undertaken as part of orientation for new staff and ongoing education. The building has a current warrant of fitness and the service has an approved fire evacuation plan.

The facilities are suitable for rest home level care and work is well underway to ensure it will also be safe for secure dementia care. An improvement is required related to the level of detail shown in the transition plan. It does not detail how the overall environment will be managed when both rest home level care and dementia care services will run concurrently. The external environment upgrades need to be completed.

Furnishings and equipment are appropriately maintained to meet residents' needs. All bedrooms are single occupancy, eight have toilet ensuites and all bedrooms have hand washing facilities. Shower areas are centrally located. The dining and lounge areas meet residents' relaxation, activity and dining needs. This includes a small quiet lounge area.

The facility is appropriately heated and ventilated through opening doors and windows. There are upgraded outdoor areas that have seating and are sheltered for residents' use.

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

The service has a lock on the two main exit doors. This is identified in policies and procedures as being for safety reasons and is discussed and consented to by residents and family/whanau upon entry to the service. It is not a selected restraint process but a safety and security measure. The access code is available to all family/whanau.

Currently resident access is limited to some outdoor areas owing to construction work. This is documented as environmental enablers and will cease when the building work is complete. Policy clearly describes enablers as voluntary and the least restrictive option.

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

The service has an appropriate infection prevention and control management system that is developed and reviewed by an infection control advisory service.

The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. The infection control programme is reviewed annually. The organisation's infection prevention and control policies and procedures reflect current accepted good practice. Relevant education is provided for both staff and residents. The monthly infection surveillance data is analysed, and where trends are identified, actions are implemented to reduce infections.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	40	0	5	0	0	0
<b>Criteria</b>	0	88	0	4	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	5
<b>Criteria</b>	0	0	0	0	0	0	0	8

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.9	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	PA Low	Following discussions with the DHB portfolio manager it was identified that a more detailed transitional plan is required to show how all risks will be managed. The plan needs to show how current rest home	Ensure the transitional plan is fully approved by the DHB and that all contractual requirements are met prior to any secure dementia care contracts being put in place.	Prior to occupancy

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>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;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>care services will be managed alongside secure dementia care services during the changeover period to meet contractual requirements. Not all items shown on the existing transition plan have been completed, for example, an orientation specific education package has not yet been presented to all staff; only two staff and the RN manager hold recognised dementia care training; and the type of philosophy for care delivery to be followed is yet to be determined (such as Eden alternative or person centred care). Family/whanau have yet to be informed of the facility's intention to offer secure dementia care.</p>		
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	Not all progress notes sighted in the six of six residents' files reviewed evidence the service provider's designation.	Ensure all progress note entries record the service provider's designation.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Three of the six residents' files reviewed do not evidence the long term care plan is developed within three weeks of admission.	Ensure the long term care plan is developed within three weeks of admission.	90
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The kitchen floor, draws and bench tops are deteriorating, with broken sections that have exposed the under surface/timber. Not all of the decanted food is dated.	Ensure the kitchen floor and bench tops are maintained to enable ease of cleaning and meet infection prevention and control guidelines. Ensure all food decanted from the original packaging is appropriately labelled and dated.	180
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			
HDS(C)S.2008	Criterion 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.	PA Low	1. There is no plan in place to show how the overall environment will be managed during the transitional period of having both rest home level care and secure dementia care services	1. Ensure all actions are undertaken to meet contractual and legislative requirements during the transition change-over period from rest home to dementia care. Actions that identify delineation of both	Prior to occupancy

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				operating. 2. The landscaping and external fencing and gates have yet to be completed.	services needs to be identified as part of the risk planning process. 2. The external work in progress needs to be completed to secure the environment.	

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

### Standard 1.1.1: 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> FA
<b>Evidence:</b> The manager/registered nurse (RN), three care staff (one enrolled nurse and two caregivers) and three support staff (one activities coordinator, one housekeeper and one cook) demonstrate and understand the rights of the residents. As observed at the onsite audit staff are seen to be addressing residents with respect, knocking on doors and asking to enter rooms prior to entering, and providing the residents with choices. The two of two family/whanau report that the service 'excels' at treating the residents with respect, dignity and maintaining the privacy of the residents.  The Aged Related Residential Care (ARRC) service agreement requirements are met.

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

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

Opportunities are provided for explanations, discussion, and clarification about the Code of Health and Disability Services Consumers Rights (the Code) with the residents and family/whānau as part of the admission process. Information about the Nationwide Health and Disability Advocacy Service is easily accessible in the main lounge/dining area. Information about advocacy services is provided as part of the admission process. The two of two family/whānau confirm the Code is discussed at admission and have high praise for the way the staff treat their family members and other residents. The six of six residents interviewed report that they are treated with respect and dignity.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

<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 1.1.3: 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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Stage one: Shoal Bay Villa Rest Home has a comprehensive policy covering abuse and neglect. It states measures to minimise the risk of abuse and neglect to residents and staff 'will be integrated into our policies, procedures and staff training in such a way that provides maximum protection without causing undue resentment by residents, staff and family/whanau'. Policy related to confidentiality and privacy identify that privacy (both visual and auditory) of residents, staff and visitors is maintained in accordance with the requirements of the Privacy Act 1993 and the Health Information Privacy Code 1994. Shoal Bay Villa Rest Home Privacy Officer (the Facility Manager) will ensure the rights of residents and staff are maintained in relation to privacy issues. Procedures show how this is undertaken. Policies cover ensuring residents' cultural and spiritual beliefs are met.</p> <p>Stage two. The above policies are observed to be implemented at the onsite audit. The six of six residents and two of two family interviewed state the service respects their personal privacy and their belongings at all times. The six of six residents' files reviewed evidence that the residents receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each resident identifies. Services are provided in a manner that maximises each residents' independence and reflects the wishes of the resident. There are key coded entrance doors, in which the residents and/or their family/whanau have consented to (confirmed in the six of six residents' files reviewed). All residents and family interviewed report that their independence is respected. All the residents and family interviewed expressed high praise for the way they are treated and the homelike nature of the service and have no concerns about abuse or neglect.</p> <p>The ARRC requirements for rest home level of care are met.</p>

**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.

<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 1.1.3.2 (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.

<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 1.1.3.6 (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.

<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 1.1.3.7 (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.

<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 1.1.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  <p>Stage one: The service has a Maori Health Plan and Ethnicity Awareness Policy/Procedure document which is identified as having input by Maori to reflect how service delivery is delivered to meet the needs of Maori in a culturally safe manner. The service acknowledges the Treaty of Waitangi framework which includes the concepts of partnership, protection and participation which the service utilise in care to ensure resident's rights are upheld and the service is resident focused. Upon admission residents cultural needs are assessed so appropriate services can be put in place to meet their needs. This includes the use of interpreter services if required. Links to Maori providers are shown including contact details.</p> <p>Stage two: The above policies are evidenced in practice at the onsite audit. The EN reports that there are no known barriers to Maori residents accessing the service. The EN reports that there is one resident who identifies as Maori. The file of this resident identifies the resident's ethnicity, iwi and religious affiliation. The resident's whanau support is documented in the resident's file. The resident was not available for interview at the time of audit as they were on leave with their whanau. The resident's file documents the cultural aspects of the resident and their whanau and outings with family. The two of two caregivers demonstrate knowledge on respecting the individual needs of the residents.</p> <p>The ARRC requirements are met.</p>

**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.

<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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

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

<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 1.1.4.5 (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> 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 1.1.6: 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> FA
<b>Evidence:</b> Stage one: Shoal Bay Villa Rest Home has appropriate policies and procedures in place to guide staff to identify and recognise individual resident's culture, values and beliefs. These are assessed at the time of entry to the service.  Stage two: The six of six residents' files reviewed evidence the individual resident's culture, values and beliefs are recorded. The two of two caregivers interviewed demonstrate knowledge on providing care that respects the individual resident's values and beliefs. The six of six residents and two of two family/whanau report that they receive care that respects their individual values and beliefs.  The ARRC requirements are met.

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

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

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

**Evidence:**

Stage one: Policy identifies that no form of discrimination will be tolerated by the service.

Stage two. As observed at the onsite audit the staff maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the resident. The two of two caregivers interviewed demonstrate knowledge of professional boundaries that still encourages a friendly and home like environment. The seven of seven staff records reviewed have position descriptions that include professional boundaries. The six of six residents and two of two family/whānau have no concerns with discrimination and speak highly of how they are treated by all staff.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Evidence-based practice is observed, promoting and encouraging good practice (evidenced in interviews with the manager and three of three care staff). Examples include policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services, palliative care services and the DHB care guidelines are utilised. The gerontological nurse specialist visits residents as required to consult regarding residents who are referred for additional care advice. The service utilises the care guidelines from the DHB and access support from the local hospice for palliative care. The service is providing ongoing education on understanding the process of dementia in preparation for the services provision of specialist dementia level of care.

There is regular in-service education and staff access external education that is focused on aged care, palliative care, dementia care and best practice. The six of six residents and two of two family/whānau interviewed expressed high satisfaction with the care delivered.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

### Evidence:

Stage one: The Open Disclosure Policy identifies that the service are committed to providing the best service available to residents in a manner that supports transparency and the relay of timely, clear accurate information and explanations recognising that communication is a two-way process. The use of interpreter services is acknowledged.

Stage two: The two of two family/whanau confirm they are kept informed of the resident's status, including any events adversely affecting the resident. The resident, and where appropriate family/whānau, are invited to attend the multidisciplinary team (MDT) review. A family/whānau communication sheet is held in each residents' file (confirmed in the six of six files reviewed). Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes (evidenced in six of six residents' files).

Wherever necessary and reasonably practicable, interpreter services are provided. The services has an interpreter service policy (as sighted at stage one of the audit). The manager/RN reports that there are no residents that currently need the use of an interpreter service.

Refer to the CAR at 1.2.3.9 regarding the action plan to inform the residents and family/whanau about the transition to the service providing secure specialist dementia care.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

### Evidence:

### Finding:

### Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

<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> <p>Stage one: The service has an informed consent form which states that all procedures will be fully explained to residents. There is also a fully described Advance Directive policy and procedure with an appropriate form for use which states the resident's wishes related to resuscitation procedures.</p> <p>Stage two: The two of two family/whānau report receiving the information book and signing an admission agreement. The two of two family/whānau and six of six residents interviewed confirm the resident's choices are respected. Written, signed consent is obtained for the collection of health information, photographs being taken, routine medical treatment, students to participate in their care, activities and outings is sighted in the six of six residents' files reviewed. All the residents' files reviewed also have the consent for the use of the key code lock at the entrances to the services.</p> <p>The three of three care staff interviewed demonstrate their ability to provide information that residents require in order for the residents to be actively involved in their care and decision-making. Staff interviews acknowledge the resident's right to make choices based on information presented to them. Staff also acknowledge the resident's right to withdraw consent and/or refuse treatment.</p> <p>Advance directives and advance care planning are made available to residents and family/whānau during the admission process and MDT review. One of the residents has an advance directive that was completed when the residents was assessed as competent. The six of six residents' files reviewed have advance care planning in which the residents and family are consulted on end of life care and treatment.</p>

ARRC requirements are met.

**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:** 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 1.1.10.7 (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> 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 1.1.11: 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> FA
<b>Evidence:</b>  Stage one: Shoal Bay Villa Rest Home policies and procedures acknowledge the residents right to advocacy and support and contact details are available to staff in policies sighted.  Stage two: The service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau are encouraged to involve themselves as advocates (evidenced in interviews with two of two family/whānau). Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information.  ARRC requirements are met.

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

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

<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 1.1.12: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Stage one: Policy identifies that links with family/whanau and other community agencies are supported and encouraged by the service.</p> <p>Stage two: The residents are able to access the community services within the community when appropriate. The service has a number of residents with cognitive impairment, and community access with family/whanau as part of the planned activities programme is encouraged. The service is located close to a church, and residents are able to access the services and social activities offered through the church. The catholic communion is available weekly for individual residents from visiting religious advisors. There are no set visiting hours and family/whānau are encouraged to visit. The six of six residents and two of two family/whānau interviewed confirm unrestricted visiting hours.</p> <p>The ARRC requirements are met.</p>

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

Consumers have access to visitors of their choice.

<b>Attainment and Risk:</b> FA
<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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The RN manager confirms that upon entry to the service complaints management is part of the information that is discussed with the resident and family/whanau. The six monthly multidisciplinary resident reviews, which family/whanau is invited to attend are also used to remind people of their right to make a complaint if they have any issues. This is confirmed during two of two family/whanau interviews. Six of six residents confirm they would voice any concerns to the senior staff member. Complaint forms are available from the quiet lounge area or from the nurses' station.

Interviews with six of six staff (one cook, the activities coordinator, one enrolled nurse (EN), two caregivers and one laundry/cleaner worker), and the RN manager, confirm their understanding and implementation of complaints management to meet policy requirements.

There is an up to date complaints register which identifies the complaints received have been responded to in writing. All actions taken to address the complaints are clearly documented and signed off when the issue has been dealt with to the satisfaction of the complainant. There are no outstanding complaints at the time of audit. One example relates to a neighbour who complained about being able to hear a resident's television at night. Resolution was gained following meetings with the resident and their family/whanau and having the residents hearing aids reviewed. All actions are clearly documented.

ARRC requirements are met.

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

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

<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 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

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

<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>

**Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: The Quality Assurance and Risk Management Programme communicates directives regarding the governance issues designed to ensure the smooth operation of all facets of the facility. 'Continuous improvement forms the basis to our management strategy and participation by all interested parties is encouraged'. Quality assurance processes are planned in advance, implemented, reviewed and action plans developed to ensure the desired outcomes are being met on a continuous basis.

Stage two: The organisation's philosophy, mission statement, and vision have a focus on quality strategies and identify that services are planned using a host of resources covering all aspects of service delivery as described in the 2013/2014 business plan sighted.

The business and quality improvement plan sighted covers care provision, education and staff development, safe and secure environment, certification and compliance. The plan identifies how the service intends to move forward to meet contractual requirements to gain approval so that secure dementia care services can be offered. Part of this includes a name change which has occurred at organisational level. The service was known as Big Guys and is now Shoal Bay Villa Limited. There have been no changes to governance.

The organisation is managed by the sole owner who is a registered nurse and holds a current annual practising certificate. She actively works within the service and undertakes all RN duties. She has over 20 years nursing experience and has owned and worked in the facility since 2007. The RN manager undertakes ongoing education related to her role which includes Bug Control infection control, Care Association New Zealand professional development seminars, District Health Board training and education days, such as communication and person centred care, and she has completed Age Care Education (ACE) dementia care papers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<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 1.2.2: 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> FA
<b>Evidence:</b> During a temporary absence of the RN manager, the EN, with the support of a RN from a nearby facility, undertakes clinical oversight, and the office administrator undertakes other reporting duties and maintains paperwork. This is identified in a contract sighted which identifies daily tasks to be undertaken in the temporary absence of the RN manager.

### 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> 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 1.2.3: 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 Low
<p><b>Evidence:</b></p> <p>Stage one: The underlying philosophy of the quality and risk programme that is in place has a focus on incremental improvement, efficiency and reduction of waste while ensuring residents receive care in the best way possible for them. The continuous improvement 'plan, do, check, act' (PDCA) cycle, is a recognised tool that incorporates the components of systems management to achieve incremental improvements. Shoal Bay Villa's quality objectives and goals cover all aspects of service delivery and are reviewed annually. This includes having up to date policies and procedures to guide staff, an internal audit process, staff education and regular meetings, good human resources processes and addressing all deficits via corrective action planning.</p> <p>The risk management policy states that it is the intent of Shoal Bay Villa to provide a safe environment for employees, residents, visitors and the general public. A risk identification document (risk register) detailing items of potential risk and their management strategy is maintained by the nurse manager. Health and Safety procedures are monitored during staff meetings. This includes newly identified hazards. The hazard register sighted identifies actions taken to manage identified hazards.</p> <p>Stage two: All policies and procedures are up to date. The organisation ensures compliance of the quality and risk management processes via the implementation of recommendations captured via quality data which is collected and collated for all key components of service (complaints, incidents and accidents, health and safety, restraint, and infection control). All trended data is compared to previously collected data and any unexplained changes are addressed using corrective action forms.</p> <p>Data is evaluated, trended and used to identify areas for improvements. An 'Annual Performance Improvement Assessment Tool' is used to identify if corrective actions put in place have achieved what was intended. Audits sighted cover all areas of service delivery. The annual performance review sighted for December 2012 identifies the goals that have been fully attained, the quality improvements that have been put in place, audit outcomes and that occupancy remained between 96-100% throughout 2012.</p> <p>All quality data which is collected is presented in graph form at monthly staff meetings and they are explained and discussed including any corrective action planning. This is confirmed in meeting minutes and during staff interviews with six of six staff. Staff report they understand and are kept well informed of all quality measures that occur.</p> <p>Quality improvements show the issue found, the corrective action taken to address the issue and the date the action was put in place. Documentation sighted identifies the success of the corrective actions put in place. For example the kitchen audit undertaken in May 2013 identified that the kitchen cleaning schedule was not always</p>

followed. A memo was sent to staff, the cleaning regime was updated, and discussions were held related to upgrade the kitchen. This has been put in the hazard register and on the building replacement schedule. (Refer comments in criterion 1.3.13.5). Follow up audits were undertaken for the following three months which identify all cleaning process are being followed.

Six monthly multidisciplinary meetings which family/whanau attends are used to share information. The RN manager stated she always asks family/whanau if they have any issues or concerns. This is confirmed in family/whanau contact sheets sighted in six of six residents' files and during two of two family/whanau interviews. The results of the satisfaction survey, which is called the 'consumer next of kin survey', undertaken in September 2013, contains no negative comments.

Actual and potential risks are identified and documented in the hazard register. They are communicated to staff and residents as appropriate. Hazards are reviewed by the RN manager and if they cannot be eliminated they are added to the hazard register. Staff confirm during interview that they understand and implement documented hazard identification processes.

There is an improvement related to the verification of secure dementia care. A more detailed service delivery transitional plan needs to be presented and approved by the DHB portfolio manager.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

**Criterion 1.2.3.4 (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.

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

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

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

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

**Criterion 1.2.3.6 (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.

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Risk management planning for current services are fully attained.  For the verification report related to the changing services required to offer secure dementia care a transition plan has been submitted to the DHB portfolio manager covering the indoor and outdoor environment, staffing levels and competence, diversional therapy, and other actions that need to occur prior to the changeover occurring. More detail is required by the DHB. The RN manager is aware of the need to ensure staff education meets secure dementia care requirements, and that all existing and new staff have an orientation specific to the introduction of dementia care. Policies and procedures are in place to guide staff actions in relation to dementia care services.
<b>Finding:</b> Following discussions with the DHB portfolio manager it was identified that a more detailed transitional plan is required to show how all risks will be managed. The plan needs to show how current rest home care services will be managed alongside secure dementia care services during the changeover period to meet contractual requirements. Not all items shown on the existing transition plan have been completed, for example, an orientation specific education package has not yet been presented to all staff; only two staff and the RN manager hold recognised dementia care training; and the type of philosophy for care delivery to be followed is yet to be determined (such as Eden alternative or person centred care). Family/whanau have yet to be informed of the facility's intention to offer secure dementia care.

**Corrective Action:**

Ensure the transitional plan is fully approved by the DHB and that all contractual requirements are met prior to any secure dementia care contracts being put in place.

**Timeframe (days):** Prior to occupancy (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:**

Stage one: Policy identifies that all accident/incidents must be reported during the shift they occur, to the manager or person in charge of the shift. The manager or person in charge will ensure that action is taken to minimise any resulting impact or loss. The manager or person in charge will ensure that corrective action is taken to reduce the chances of similar future occurrences. The primary purpose of accident/incident or quality improvement/corrective action investigations is not to direct blame, but rather to identify the cause/s of the event and take corrective action to prevent future similar occurrences. The form used to record incident and accidents identifies statutory obligations to report serious injury.

Stage two: The RN manager understands her role in ensuring statutory and regulatory obligations are met in relation to essential notification reporting.

All incidents and accidents are recorded on a specific form. Adverse event data is collated and trended against previously collected data. Incident and accident information is used to identify areas of improvement as appropriate. Information is shared at staff meetings as shown in minutes sighted and confirmed during seven of seven staff interviews.

Family/whānau are kept informed of all incidents, accidents, adverse events or concerns as confirmed in six of six residents' files and during two of two family/whānau interviews. For example a resident had an unexplained fall and observations are recorded, urine was sent to the laboratory, full medical review undertaken and the resident has had specialist input. All events have been reported to family/whānau.

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

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

**Attainment and Risk:** FA**Evidence:**

<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 1.2.4.3 (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> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Policies and procedures implemented identify that good employment practice and legislative requirements are met. This is confirmed in a review of seven of seven staff files (the RN manager, one EN, the activities coordinator, one cook, one laundry/cleaner person and two caregivers). Signed job descriptions and employment contracts are sighted.</p> <p>Staff orientation and induction processes are documented. Education records identify that staff undertake education related to their role. This includes food safety, safe chemical handling, emergency education, infection control, restraint management and regular clinical in-service education. Interviews with six of six staff confirm the education they attend is relevant to their role and that they are encouraged to undertake Aged Care Education (ACE) qualifications. Three staff, one being the RN</p>

manager, hold ACE dementia care qualifications.

Six of the seven files reviewed show that annual appraisals are up to date. The one outstanding appraisal shows that an appointment has been made with the staff member to do this. Annual education calendars sighted for 2012 and 2013. Eleven staff hold a current first aid certificate which ensures there is always a staff member of duty with the qualification.

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

The RN manager is aware that all staff are required to complete an orientation process related to providing services for secure dementia care. Refer comments in criterion 1.2.3.9.

Interviews with residents and family/whanau and the satisfaction survey results identify residents' needs are met by the services delivered.

**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.

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

**Criterion 1.2.7.3 (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> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

**Criterion 1.2.7.5 (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

**Attainment and Risk:** FA

### Evidence:

Stage one: Policy states staffing levels and routine rostering will be determined by the RN manager taking into consideration the assessed needs (acuity) of residents and associated roles, responsibilities and levels of experience of staff.

Stage two: Four weeks of rosters reviewed identify that staff are replaced for sick leave and annual leave. The EN works four days a week for 30 hours. The RN manager works Monday to Friday and is on-call 24 hours a day, seven days a week. The GP is on-call at all times.

- Laundry/cleaning is undertaken by a dedicated person 7.5 hours six days a week and by a nominated caregiver for reduced hours on a Sunday.
- There is a cook on duty 9am to 6pm seven days a week.
- The activities coordinator works 19 hours per week. The RN manager reports that more dedicated activity hours will be put in place once dementia care is approved.
- Maintenance and gardening are contracted out on an on call basis.

### Caregiver cover:

7.00am to 3.30pm - two caregivers Monday to Saturday and three caregivers on a Sunday.

3.00pm to 11pm – two caregivers

11pm to 7.00am – two caregivers

One senior/experienced staff member covers all shifts. During staff interviews they confirm they have time to complete all documented tasks and resident cares.

The RN manager will identify how the transition from rest home to dementia care will be managed by staff in a transition plan to go the DHB portfolio manager. Refer comments in criterion 1.2.3.9.

## Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

**Attainment and Risk:** FA

### Evidence:

### Finding:

<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

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>The six of six residents' files sighted have information that is recorded in an accurate and timely manner. The initial administration data and information about the resident is collected on the day of admission. Any changes to the resident and family/whanau details are updated as the changes occur. Current and archived information is stored securely in the nurses' office or storage room in the attic area. There is no personal or private information on public display at the time of audit.</p> <p>Each resident has one main clinical file that contains their information. The service uses a separate folder that contains the most recent progress notes and any monitoring forms (eg, observations, weight, and behaviour monitoring charts). Both these files evidence integration, are easy to access and securely stored in the same cabinet. The EN reports that they have had no issues with having the current progress notes and monitoring forms in the separate folders. The six of six residents' files evidence integration with the multidisciplinary team.</p> <p>Refer to CAR at 1.2.9.9 to ensure all progress note entries record the service provider's designation.</p> <p>The ARRC requirement at D7.1 is partially met, with the other relevant rest home level of care requirements met.</p>

**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.

<b>Attainment and Risk:</b> FA
<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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (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.

**Attainment and Risk:** PA Low

**Evidence:**

The progress notes sighted in the six of six residents' files do not have the service providers designation recorded on all progress note entries. In the six of six residents' files sighted there are two staff signatures that do not consistently record the service provider's designation, with all other entries and staff members recording their designation in the files. The service also has a register of the staff member's name, signature and designation for an additional means to identify the signatures. At the time of audit the EN provided additional education to the staff members that are not consistently recording their designation. A corrective action is required to ensure the service provider's designations are recorded on all progress note entries.

**Finding:**

Not all progress notes sighted in the six of six residents' files reviewed evidence the service provider's designation.

**Corrective Action:**

Ensure all progress note entries record the service provider's designation.

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

**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> 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>

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>At the time of audit the service offers rest home level of care. The services entry policy describes the entry criteria and clearly describes that the potential resident requires an assessment for rest home level of care. The EN/care coordinator reports that residents also are required to be assessed for the room that is available, for example residents in the upper level are required to be able to use stairs safely. The EN/care coordinator reports that full details of the residents are obtained prior to entry to ensure the service can meet the needs of the potential resident. This assessment includes aspects of the clinical care as well as any behaviour management issues or special needs. Also refer to 1.2.3.9 for the services transition plan for introducing dementia level of care.</p> <p>The ARRC requirements for rest home level of care are met.</p>

#### 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.

<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 1.3.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>When it is ascertained that the service cannot meet the needs of the potential resident, or that the resident does not have the appropriate assessment for rest home level of care, the manager will contact the service coordination team. If entry is declined it is recorded on the 'declined entry' form, which records any arrangements made to refer the resident to the service coordination team or the information given on the appropriate level of care. The manager reports that they have not declined entry when there are beds available and the resident has an appropriate assessment for rest home level of care.</p> <p>The resident admission agreement is based on the NZ Aged Care Association agreement and documents when the agreement can be terminated or when there are changed needs and the needs can no longer be met by the service. When there are changed needs the service will ensure there is an appropriate re-assessment, assist the resident or family/whānau to find an alternative facility and ensure that the transfer occurs in an appropriate and timely manner.</p>

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>Stage one: The Clinical Management policy identifies that each stage of service provision is undertaken by a RN. Long term care plans must be completed within three weeks of entry. They are reviewed at least six monthly with three monthly medical reviews. The resident and their representative / advocate / family/whanau are encouraged to have input into the development and reviews of the care plan which is evidenced in writing on the care plan and/or in the 'Family Contact Form'.</p> <p>Stage two: The long term care plan is a standardised template that is individualised to the resident's needs. The care plan documents the issue, goal/objectives, interventions, family involvement in the care plan development and review, and review/evaluation of care. The initial assessment covers the activities of daily living, physical needs, psycho-social, spiritual and cultural needs of the resident. Additional assessments include behaviour management, pain management, falls risk, pressure area risk and nutrition needs. The standardised needs on the care plan are safety/potential for injury, mobility, continence, activities of daily living, medication, dietary needs, pain management, sleep/comfort, communication/sensory, memory loss/confusion, respiratory function, behaviour management, psycho-social, culture, sexuality and intimacy, skin/wound care, activities, and other needs. The occupational therapy assessment and therapy plan are on a separate form. The service routinely conducts observations monthly (temperature, pulse, respiration, blood pressure and weight). There is an improvement required to ensure the long term care plan is developed within three weeks of the resident's admission.</p> <p>Each stage of service provision is undertaken by suitably qualified and/or experienced service providers. The RN or EN conducts the assessment, care planning, review and evaluation of care. When the EN has conducted an assessment or developed a care plan, this is signed and authorised by the RN. The caregivers provide most of the direct resident care (also refer to 1.2.7 for training, qualifications, practicing certificate and ongoing education processes). The GP conducted the medical assessment and medical reviews. The six of six residents and two of two family/whanau report satisfaction with the staff and provision of services.</p>

The services are delivered in a manner that reflects continuity of care. There is a verbal handover at the start of each shift. The two of two caregivers report that they receive adequate information at the verbal handover and updates on residents with any changed conditions. The progress notes are updated at least daily on morning shifts, and on other shifts if there are any changes in the resident's condition or care provision.

Tracer example

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

The ARRC requirement of D16.2b and D16.3c are partially met. All other ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Three of the six residents' files reviewed have the long term care plans developed within three weeks of admission. The remaining three residents' files reviewed evidence the long term care plan is developed more than three weeks after admission. These long term care plans are developed at four, five and eight weeks respectively. A corrective action is required to ensure the long term care plan is developed within three weeks of admission.

**Finding:**

Three of the six residents' files reviewed do not evidence the long term care plan is developed within three weeks of admission.

**Corrective Action:**

Ensure the long term care plan is developed within three weeks of admission.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Procedure and assessments are sighted for catheter and continence management, acuity assessment form which covers all aspects of clinical care, challenging behaviour assessment. The falls assessment and management plan encompasses Coombes assessment. A Mobility Support guide is used for a quick reference of residents mobility needs. There is a Health Status and Clinical Risk assessment form which covers skin integrity. The Abbey Scale pain assessment is used by the service. Wound, skin care management, assessments and staff competencies are included in policy.

Stage two: The above process and assessments are implemented, as confirmed in the six of the six residents' files reviewed at the onsite audit. The service has not yet completed InterRAI training, which is scheduled for April 2014. The six of six initial or long term care plans sighted reflect the assessed needs of the resident. The service uses a standardised set of assessment tools, such as for falls risk, pressure area risk, nutrition, pain and continence. Where the resident has any additional needs, other specialised assessments are conducted. The assessments are reviewed within the six monthly evaluation of care, as confirmed in the three files reviewed of residents with admission over six months. The resident reviewed using has assessments for mobility, falls risk, pain and nutrition that are re-assessed as the resident's condition changed. One of the other files reviewed is of a resident with behaviours that challenge, and this resident has a behaviour assessment and monitoring forms that reflect

the assessed unmet needs of the resident. The behaviour assessment includes the triggers and how the resident responded to the interventions.

The six of six residents and two of two family/whanau interviewed report satisfaction with the care that is provided.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Individual residents who have repeat falls have an analysis form in their file.

Stage two: The six of six initial or long term care plans sighted are individualised to the resident's needs and promote continuity of service delivery. The long term care plan describes the required supports and interventions to achieve the desired outcomes. The resident reviewed using has interventions recorded for their changed needs related to falls, pain management and re-occurring urine infections. The two of two caregiver's report that they are provided with adequate information to provide care and that the care plans reflect the current needs of the residents.

The six of six residents' files reviewed evidence continuity of care. The resident's files reviewed evidence a multi-disciplinary team approach to care and appropriate referral to specialists as required to meet the residents' needs.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (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:**

The six of six residents' files reviewed evidence the provision of services are consistent with meeting the resident's assessed needs and desired outcomes. The care plan format includes detailed guidance for care delivery staff to support the achievement of residents' goals. The service has adequate dressing and continence supplies to meet the needs of the residents.

Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The six of six residents and two of two family/whanau interviewed report that the service meets the needs of the resident. The resident reviewed evidences an acute illness with appropriate nursing and medical review. The two care staff interviewed demonstrate knowledge on the ongoing interventions to minimise urinary infections, the signs that the resident may be in pain and the encouragement of food and fluids for weight management.

The six of six residents and two of two family/whanau confirm their satisfaction with the services provided.

The ARRC requirements for rest home level of care are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The occupational therapy assessment sighted in the six of six residents' files include the residents level of function, current hobbies and interests, social life history, spiritual, religious and cultural aspects. The weekly activities plan (sighted) is developed based on the resident's needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident, with the activities co-ordinator giving an example of the services encouragement of mobility and independence of the residents, with frequent walks and outings to the community.

The daily activities attendance sheet is maintained and reviewed at the end of each month to assess the enjoyment and interest of the residents. The goals are updated and evaluated in each resident's file at least six monthly.

The six of six residents interviewed report they enjoy the range and variety of planned activities.

The activities coordinator has attended ongoing education on dementia care, and report that they have already modified the activities for the residents that do have cognitive impairment. The activities coordinator reports that they have commenced the national modules on specialist dementia care.

The ARRC requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Three of the residents' files reviewed are of residents' with admissions over six months, in all these file the six monthly evaluation of care documents a comprehensive review. The six monthly evaluations sighted are resident focused and indicate the degree of achievement or response to interventions, and progress towards meeting desired goals. The short term care plans sighted also record an evaluation of the interventions.

Where progress is different from expected the service uses short term care plans for acute episodes of care. The six of six residents' files sampled demonstrate that the long term care plans are reviewed and updated as needs change. Short term care plans are used to document temporary changes or acute needs.

The ARRC requirements are met.

### 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.

<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 1.3.9: 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> FA
<b>Evidence:</b> <p>The rights of residents to access other health and/or disability providers is maintained. If the need for other services is identified or requested, the GP, manager/RN or EN sends a referral to seek specialist provider assistance. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services as required or requested. The majority of residents used the contracted GP services, with GP visiting at least weekly.</p> <p>The resident reviewed evidenced referral to outpatient's clinic and medical specialist. The six of six residents and two of two family/whanau report they are consulted and kept informed about referrals of their family member to other health services, and that their choices are respected.</p> <p>The ARRC requirements are met.</p>

**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> 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 1.3.10: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Every resident's file includes a yellow transfer envelope system, designed to facilitate resident transfer between health services. When a resident is transferred a copy of the GP referral letter, a continuity of care form, copy of their EPO, advanced directive, and any other relevant information is included in the transfer envelope. Any risks are identified on the transfer/discharge information. The resident reviewed has some cognitive impairment and has no specific memory of when they were transferred to the acute care hospital.  The ARRC requirements are met.

**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.

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

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

**Standard 1.3.12: 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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Stage one: Policy identifies that medication management is a shared responsibility between prescribed Doctor, Pharmacist (and associated personnel), Nurse Practitioner/s and the facility Registered Nurses. All team members will be committed to practicing in accordance with the Ministry of Health 'Medicines Care Guides' and related current legislation and current best practice. The Facility Manager will ensure quality and risk management processes are implemented to support safe management of medication. There are detailed responsibilities for each stage of medicine management. Staff must hold a medicine competency before they can administer medication. Residents that self-medicate are assisted to ensure accurate and timely supplies of medication are available and these are administrated safely and stored appropriately.</p> <p>Stage two: The service has most medicines delivered by pharmacy in the Medico Pak delivery system. The Medico Paks have the content checked and verified for accuracy by the EN/care coordinator when the Paks are delivered (verification signature sighted on the signing sheet and a content verification register). The medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Resident photo, allergies and sensitivities are recorded on the medicine chart and medicine prescription. All medicines sighted are individually prescribed for the residents. Sample signatures are documented. The 12 of 12 medicine administration records sighted are fully completed.</p> <p>Medicines are stored securely in the nurses' office, with the medicine trolley securely stored in a locked cupboard when not in use. Controlled drugs are stored in a safe in the nurses' office area. The controlled drugs are checked out by two staff at each administration with a weekly count recorded in red pen in the controlled drug register.</p> <p>Medication competencies are sighted for the care staff who assist with medicine management. The medicine competencies are conducted annually.</p> <p>The controlled drugs are stored in a drug safe in the nurses' office. The controlled drug register sighted is signed by two staff at each administration. There is a weekly check of the controlled drugs recorded in the controlled drug register.</p> <p>Of the 12 medicine files reviewed one of these is two weeks overdue for the three monthly GP review of medicine and one of the signing sheets has a medicine (inhaler) ordered by the GP to be given twice a day, though the signing sheet records daily administration. These do not reflect systemic issues and are addressed on the day of audit.</p>

The EN reports that there is one resident who self-administers some of their medicines (eye drops). The resident has a competency assessment that identifies the resident is competent to administer their eye drops.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b> The resident assessed as competent to self-administration, has the assessment last conducted in June 2013
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Stage one: Residents nutritional requirements are assessed upon admission. This includes likes and dislikes. All staff working in this area are required to undertake education in Infection Control practices and Safe Food Handling. Verification must be maintained on each relevant staff members personnel file. There is food service manual covering all aspects of current safe food guidelines.

Stage two: Resident nutritional assessments are sighted in the six of six residents' files reviewed. On admission to the facility, all residents complete a dietary assessment form which includes their preferences and dislikes. Copies of these forms are held in the kitchen, as well as details of individual's preferences/dietary needs. Any subsequent changes to residents' nutritional or hydration needs must be double-signed prior to the kitchen implementing any changes. A range of dietary needs can be catered for, including diabetic, pureed and low sodium diets, and specialised feeding equipment (feeding cups, lip plates) are available as required.

The four week rotational menu, with seasonal variations, is last reviewed by a dietitian in October 2013. The menu is reviewed against the nutritional guidelines for residents living in long term care. Residents are weighed monthly (sighted in six of six residents' files reviewed). Regular fluid rounds are undertaken and jugs of water are available at each meal.

On inspection, the kitchen is noted to be clean and tidy, the linoleum surfaces on the floor, draws and bench tops are deteriorating, with broken sections that have exposed the under surface/timber. All foods are in their original packaging or when decanted are appropriately labelled, though not all of the decanted food is dated. There is a stock rotation system. These aspects require corrective action. The fridge and freezer temperatures are recorded daily, and are maintained within the required range. The kitchen staff have food safety training.

Verification: Dementia unit. The manager/RN confirms that nutritious snacks are already available 24 hours a day for the residents. The cook also confirms that there is capacity in the kitchen to cater for these residents, and the numbers of residents will not increase. The kitchen has had a security screen installed on the day of audit, to ensure the kitchen is secure when not in use.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

<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> PA Low
<b>Evidence:</b> <p>On inspection, the kitchen is noted to be clean and tidy, the linoleum surfaces on the floor, draws and bench tops are deteriorating, with broken sections that have exposed the under surface/timber. The service has already identified the kitchen as an area that is planned for refurbishment and have a documented action plan to addresses this issue. A corrective action is required to ensure the kitchen floor and bench tops are maintained in a standard to enable ease of cleaning and reflect infection prevention and control guidelines.</p> <p>All foods are in their original packaging or when decanted are appropriately labelled, though not all of the decanted food is dated. A corrective action request is made to ensure all food decanted from the original packaging is appropriately labelled and dated.</p>
<b>Finding:</b> <p>The kitchen floor, draws and bench tops are deteriorating, with broken sections that have exposed the under surface/timber. Not all of the decanted food is dated.</p>

**Corrective Action:**

Ensure the kitchen floor and bench tops are maintained to enable ease of cleaning and meet infection prevention and control guidelines. Ensure all food decanted from the original packaging is appropriately labelled and dated.

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Policy states that the storage of chemicals will be in accordance with manufacturers labelling in the chemical store room as per guidelines shown. Material safety data sheets are available for all chemicals used a Shoal Bay Villa. The Waste Disposal policy aims to ensure the risk of contamination is minimised while disposing of waste in a safe and appropriate manner. Processes are fully described.

Part two: Chemicals are supplied by an approved supplier who ensures safety data sheets are kept up to date. Safe use of chemicals is included in infection control education as sighted in educational material viewed. All chemicals are securely stored in a locked cupboard and the laundry is kept locked when not in use.

Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons and goggles. Interviews with six of six staff confirm they can access PPE at any time. Staff are observed wearing disposal gloves and aprons as required.

Approved yellow sharp bins sighted are used for the safe disposal of sharps.

The service undertakes appropriate storage and disposal of waste, infectious and/or hazardous substances to comply with current legislation. There are no specific territorial authority requirements related to waste care management.

**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.

<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 1.4.1.6 (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> 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 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

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

**Attainment and Risk:** PA Low

### **Evidence:**

All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 06 September 2014. Maintenance is undertaken by an external contractor as required. This is confirmed in the maintenance book sighted. Long term maintenance is identified in the business plan. Electrical testing occurred in February 2012 by an approved provider.

Biomedical and medical equipment which includes sphygmomanometers, stand on scales and stethoscopes have been purchased within the last 12 months. There is a new industrial washing machine, purchased in July 2013, which records cycle types and water temperatures. The vacuum cleaner was purchased in February 2013.

The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas not being cluttered. Corridors have safety handrails to assist residents to mobilise safely. There are stairs which separate one level from another. The RN manager confirms there have no incidents or accidents that involve the stairs. They are wide, have secure hand rails on both sides and secured flooring. Residents are sighted using the stairs without difficulty and safely throughout the audit.

Regular environmental audits sighted identify that the maintenance plan is undertaken as required. All completed work is signed off by the RN manager. This has identified issues with floor and bench surfaces in the kitchen and the service business plan identified the kitchen refurbishment will be undertaken when finances allow. Refer comments in 1.3.13.5

External areas have been upgraded, and include an internal courtyard with raised edible gardens, shaded areas and high fences. During audit this area was used by residents for reading, socialising and watering the gardens. This upgrade is to be completed to incorporate the front of the facility. Hazard signs are clearly displayed. The service also needs to show how they will manage the environment to cater for both rest home and secure dementia care residents during the transitional period. This is identified as an area for improvement.

The fence at the back of the property has not been increased in height but there is no resident access to this area.

Interviews with six of six residents and two of two family/whanau members confirm the environment is suitable to meet their needs.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

### **Evidence:**

<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> PA Low
<p><b>Evidence:</b></p> <p>The environment is suitable for current rest home level care services. Locks on the front doors are identified as part of everyday services and are discussed and consented as part of the admission process. Residents and family/whanau have the key code number as confirmed during interview. The locks are for safety and security reasons only. (Whilst landscaping and outdoor fencing is being undertaken the service has identified this as an environmental enabler. Refer comments in 2.1.1.1).</p> <p>The transition plan sighted shows how the external environment will be managed for secure dementia care, but not how the internal environment will be managed when there are two services being operated.</p>
<p><b>Finding:</b></p> <ol style="list-style-type: none"> <li>1. There is no plan in place to show how the overall environment will be managed during the transitional period of having both rest home level care and secure dementia care services operating.</li> <li>2. The landscaping and external fencing and gates have yet to be completed.</li> </ol>
<p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1. Ensure all actions are undertaken to meet contractual and legislative requirements during the transition change-over period from rest home to dementia care. Actions that identify delineation of both services needs to be identified as part of the risk planning process.</li> <li>2. The external work in progress needs to be completed to secure the environment.</li> </ol>
<b>Timeframe (days):</b> Prior to occupancy <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> 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 1.4.3: 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> FA
<b>Evidence:</b> <p>There are adequate numbers of toilet and shower. Eight bedrooms have toilets, six bedrooms have a toilet located for use between two bedrooms and there are toilets and showers centrally located throughout the facility which have locks to ensure resident privacy can be maintained when attending to personal hygiene requirements.</p> <p>Sanitising hand gel is available in all areas. Hot water temperatures are monitored and recorded to ensure they remain below the required 45oC safe temperature.</p> <p>There are separate staff and visitor toilets.</p>

**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> 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 1.4.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> All bedrooms are single occupancy. They are personalised to meet residents' wants and needs and are large enough to allow residents with or without mobility aids to move around safely. Resident's personal belongings are stored in their bedrooms.  Interviews with residents and family/whanau confirm they are happy with their bedrooms.

**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.

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. The dining and lounge area are separated by flooring and the placement of furniture. There is a separate quiet lounge. Activities are undertaken in the main lounge area.

There is also a small area opposite the kitchen which has a table and chairs but is not currently used at meal times for residents.

Interviews with six of six residents and two of two family/whanau members confirm they feel all their internal environmental needs are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Linen handling process are clearly described and focus on meeting all good infection control standards.

Stage two: The laundry/cleaner confirms during interview that all documented laundry and cleaning process are implemented and that she had sufficient time to complete all tasks. As observed PPE is readily available and used appropriately during cleaning processes.

All chemicals sighted are appropriately labelled and securely stored in the locked cleaners' cupboard and in the laundry area which is kept locked when not in use.

There is a commercial washing machine and dryer in the laundry. The laundry only caters for resident's personal washing and the bed 'kylies'. All other laundry is contracted to an offsite service. There is an area in the laundry to which the clean laundry is delivered. Owing to the age of the building it is difficult to see a clear clean/dirty flow and this is one of the reasons the RN manager decided to contract out the laundry service.

Stage one: Linen handling process are clearly described and focus on meeting all good infection control standards.

#### **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> 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 1.4.6.3 (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> 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.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a well-stocked emergency trolley (evacuation trolley) which is checked regularly to ensure all equipment and supplies are within expiry dates. This includes food and water supplies. The facility has gas cooking and there is a BBQ should it be required in case of an emergency.

The approved emergency evacuation plan was updated and signed off by the New Zealand Fire Service on 10 October 2013. There have been no changes to the facility foot print since this time. Six monthly trial fire evacuations are conducted. Last undertaken on 17 September 2013 and 10 staff attended.

Fire equipment was checked by an approved provider in April 2013.

The RN manager and documentation sighted confirms that 11 staff hold current first aid certificates to ensure there is always a staff member on duty in case of an emergency.

Staff are required to ensure doors and windows are securely closed at night. This is confirmed by two caregivers, one who works afternoon shift and one who works both afternoon and night shift. Two main external doors are kept locked at all times. All residents and family/whanau are provided with the key code and they sign a consent form upon admission to say they understand this is for safety and security reasons.

Call bells are sighted in all residents' bedrooms. When the bell is activated a light goes on outside the resident's room and shows on a board outside the kitchen area which is where the nurses' room is located. The bell has an audible sound that can be heard throughout the facility.

Bedrooms located at the back of the building have patio locks on all doors and window stays to ensure security. During the days of audit a roller door grill was installed in the kitchen to prevent residents being able to access the area when staff are not on duty. As part of the transition planning the RN manager is considering installing CCTV to cover all entrances, hallways and the main gate. The internal garden area can be fully secured. As identified in 1.2.3.9 planning needs to identify how two services will be managed during the transition process of converting from rest home to secure dementia care.

**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> 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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

<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 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

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

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

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

<b>Attainment and Risk:</b> 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 1.4.7.6 (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> 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 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All resident areas have at least one opening window and/or door which provide natural light and ventilation. The facility is heated by use of electric and gas heating. Each resident's bedroom has an electric heater. The facility is currently replacing all bedroom heaters with wall mounted eco heaters. Existing heaters are high wall mounted heaters. The facility was warm and well aired on the days of audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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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:**

Stage one: Policy identifies that the service is committed to achieving and maintaining a restraint-free environment. In the event that all other alternatives have been unsuccessfully trialled, restraint will be used as a last resort to ensure the physical safety of the resident concerned, and/or other residents, staff and visitors. There are guidelines for staff to follow regarding the use of restraints and enablers. Enablers are described as any device or process used with the intention of promoting resident independence, comfort and safety and to which the use of the enabler is voluntary, thereby meaning the resident may choose to have the enabler implemented or not. This requires the resident's input and ability to give informed consent and results in a limit to their normal freedom of movement.

Stage two: There are number key code locks on the two front entry doors for security reasons the RN manager stated that residents and family/whanau are informed of this as part of the entry process and that this is signed for as part of the consent process as identified in six of six resident file reviews. Residents and family/whanau are given the code numbers for the doors as appropriate. Policy identifies the rationale for this being for safety reasons. The RN manager confirms the locked doors are linked to the fire system and in case of an emergency automatically unlock to meet warrant of fitness legislative requirements.

Interviews with six of six staff, the RN manager and observation confirm there is no restraint in use at the time of audit. However, the facility is currently having outdoor renovations undertaken which includes new gardens, paving and fencing in anticipation of being able to offer secure dementia care. Whilst the construction process is being carried out resident access to outdoor areas has been restricted for safety reasons. This is documented as an environmental enabler and 25 signed consent forms are sighted in the restraint register. Assessment identifies that this is to be put in place to ensure resident safety related to identified hazards generated by the construction work that is being undertaken. This process includes a letter being sent to all resident family/whanau or nominated representatives to explain why this was required and seeking signed consent. The construction commenced in October 2013 and a central outdoor garden area is fully completed at the time of audit. As

observed on the days of audit, residents freely access this area. The front garden area is still under construction and there is restricted access to this. The RN manager stated the environmental enabler consent will cease when all the building work is completed.

**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.

<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>

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

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

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

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

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

<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 2.2.3.5 (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> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Services evaluate all episodes of restraint.

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

<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>

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

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

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

ARC 5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** Not Audited

**Evidence:**

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

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

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

**Attainment and Risk:** 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.)

# 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

**Attainment and Risk:** FA

**Evidence:**

The service utilises infection and prevention control resources from an external infection control advisory service. The infection control nurse consultant from the infection control advisory service chairs the organisation's infection control committee. The standard agenda for the meeting provides evidence of monthly infection surveillance reports, internal audits, influenza vaccinations and discussion of the refurbishment of the laundry and kitchen. The monthly surveillance data is reported at the quarterly infection control committee meeting. The manager/RN is aware of the reporting of infectious diseases. If there is an infectious outbreak this is reported immediately to staff by the manager/RN and where required, to the DHB and public health departments.

The service has an infection control strategic plan, dated February 2013, which has strategies in place for leadership and management, risk management and infection control, quality monitoring and infection surveillance, education of staff, residents and visitors, and employee health. The infection control programme was externally reviewed by an infection control nurse consultant in August 2013. The review of the infection control programme covered the general appearance of the facility, the infection control protocols, clinical aspects of infection prevention and control, linen and laundry services, food services and general cleaning. From the review of the infection control programme the service has developed an action plan to address the recommendations.

A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. The six of six staff interviewed are able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing, cleaning and cooking.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The day to day management of the infection preventing and control strategies are managed by the manager/RN. The service has an external infection advisor involved in the development and review of the infection control programme and ongoing committee meetings. The infection control committee consists of the external infection control nurse consultant, the managers/RN, representatives from care staff, activities and kitchen. The manager attends the infection control team meeting which are conducted at least four times a year (minutes sighted for February, April, July, October 2013 sighted). The manager/RN demonstrates sound knowledge of current accepted good practice in infection prevention and control.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The services infection prevention and control policies and procedures are developed by an external infection control advisory service. There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and referenced to current accepted good practice. References to Australian and New Zealand research and best practice are included in the infection prevention and control policies and procedures. The two of two caregivers interviewed knew where to locate the infection control manual and are aware of its content. Observations at the onsite audit identify the implementation of infection prevention and control procedures. Staff demonstrate safe and appropriate infection prevention and control practices.

Verification: The manager/RN reports that no changes will required to the infection prevention and control policies and procedure for the proposed change to dementia level of care.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control education is undertaken by an infection control nurse from the external infection control advisory service. The education resources are provided by the advisory service and referenced to current accepted good practice. The infection control nurse has conducted infection preventing and control education in April and October 2013. The service maintains records of the infection control education that contains record of who has attended, aims, objective, contents and evaluation summaries. The service also uses the advisory services infection control booklet for orientation of new staff members.

There is informal resident education that is conducted as required. The EN reports informal education on personal hygiene can be conducted for residents with reoccurring infections.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<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 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> <p>Policy clearly sets out surveillance data collection requirements, based on the guidelines from the infection control advisory service. The manager/RN or EN are responsible for the monthly surveillance of nosocomial infections, implementation of quality improvement plans and feedback to all staff through meetings.</p> <p>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. Any infections are reported to staff at handover. The infection control committee reviews and trends the surveillance data. When increased infections or trends are identified the service develops actions to reduce the occurrence of infections. The infection surveillance report and analysis identifies an increase in respiratory tract infections in July, August and September 2013. The analysis records that this is a seasonal variance and reflective of community norms (range from 4-6 recorded infections). There is one respiratory tract infection recorded for October 2013.</p>

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

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

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

<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>