Golden Concept Group (NZ) Limited

Current Status: 16 January 2014

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

General overview

Dominion Home provides dementia level care for up to 29 residents. On the day of the audit there were 24 residents including one resident on short term respite care. The service changed ownership in March 2013 and the previous owner/manager has remained in post as the general manager. The general manager has many years' experience in the industry and has owned the facility for four years prior to the sale. The general manager is supported by a registered nurse. The care services are holistic and promote the residents' individuality and independence. Family interviewed all spoke positively about the care and support provided. The general practitioner was positive in his feedback when interviewed.

This audit identified improvements required by the service around documenting incidents, providing a secure environment, training for the infection control coordinator, aspects of care planning and activity plans.

Audit Summary as at 16 January 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 16 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Organisational Management as at 16 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Continuum of Service Delivery as at 16 January 2014

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

Safe and Appropriate Environment as at 16 January 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.

Restraint Minimisation and Safe Practice as at 16 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Infection Prevention and Control as at 16 January 2014

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

Audit Results as at 16 January 2014

Consumer Rights

Dominion Home provides care that focuses on the individual residents. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the Code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Family members interviewed verify ongoing involvement with community groups and confirm visiting can occur at any time.

Organisational Management

Dominion Home has a 2013 -2014 business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality framework being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Quality information is reported to staff monthly and three monthly integrated quality assurance committee meetings. Family members are provided the opportunity to feedback on service delivery issues at three monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to the staff and quality meetings. There is an improvement required around documenting all incidents.

Dominion Home has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service programme that has been implemented for the 2013 year and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and caregivers report staffing levels are sufficient to meet resident needs.

Continuum of Service Delivery

The service has a comprehensive information pack that is given to all inquiring families. Entry criteria and access process are clearly defined in policy and the resident information pack.

The registered nurse carries out admission procedures. The registered nurse develops assessments and care plans. Cares and support are primarily provided by caregivers under the supervision of the general manager/ registered nurse.

A range of assessment tools are completed in resident files on admission and completed at least six monthly. Risk assessment tools and monitoring forms are available and implemented including behavioural management plans for each resident. Resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Service delivery plans are individualised. Short term care plans are in use for changes in health status. The general practitioner and other health professional's document notes in the resident file and residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility. An improvement is required to updating the care plan as changes occur.

An activities coordinator works seven hours per day, four days per week. There is a programme planned for that includes games, TV, movies, arts and crafts, exercises, garden walks, entertainers and hand therapy. Activities are supported by caregivers outside of the activities coordinators hours. Family members interviewed report residents enjoy activities and all state that there is always something happening when they come into the service. An improvement is required to documentation of a 24-hour activity plan.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary.

Food services policies and procedures are appropriate to the service setting with nutritional snacks available on a 24-hour basis. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines.

Safe and Appropriate Environment

There is a current building warrant of fitness The facility is maintained with contractors used when required. There is a refurbishment programme in place. There is a safe and secure external area for residents to access. The external and internal environment is arranged with a lot of space for walking and indoor/outdoor activities. Corridors are wide enough in all areas to allow residents to pass each other safely and there are safety rails appropriately located.

Staff confirm that they have access to appropriate equipment, that equipment is checked before use and staff are competent to use the equipment. The facility provides evidence of safe storage of equipment with equipment calibrated annually.

Chemicals are safely stored with a trolley that is kept secure when in use. There is an improvement required around providing a secure environment.

Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Resident files sampled have detailed plans around the management of behaviours that challenge. There are no residents using enablers.

Staff received training around maintaining a restraint free environment, including the management of behaviours that challenge in January 2012.

Infection Prevention and Control

The infection control nurse is the registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. There is an improvement required around training for the infection control coordinator. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to the quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. There have been no outbreaks since the previous audit.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Golden Concept Group (NZ) Limited
Certificate name:	Golden Concept Group (NZ) Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit			
Premises audited:	Dominion Home			
Services audited:	Dementia care			
Dates of audit:	**Start date:**	16 January 2014	**End date:**	16 January 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	24

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	5
Other Auditors	XXXXX	**Total hours on site**	8	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	12	Total audit hours	28

Number of residents interviewed		Number of staff interviewed	9	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	21	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Wednesday, 5 March 2014

Executive Summary of Audit

General Overview
Dominion Home provides dementia level care for up to 29 residents. On the day of the audit there were 24 residents including one resident on short term respite care. The service changed ownership in March 2013 and the previous owner/manager has remained in post as the general manager. The general manager has many years' experience in the industry and has owned the facility for four years prior to the sale. The general manager is supported by a registered nurse. The care services are holistic and promote the residents' individuality and independence. Family interviewed all spoke positively about the care and support provided. The general practitioner was positive in his feedback when interviewed. This audit identified improvements required by the service around documenting incidents, providing a secure environment, training for the infection control coordinator, aspects of care planning and activity plans.

Outcome 1.1: Consumer Rights
Dominion Home provides care that focuses on the individual residents. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ('the Code') is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Family members interviewed verify ongoing involvement with community groups and confirm visiting can occur at any time.

Outcome 1.2: Organisational Management
Dominion Home has a 2013 -2014 business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality framework being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to staff monthly and three monthly integrated quality assurance committee meetings. Family members are provided the opportunity to feedback on service delivery issues at three monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to the staff and quality meetings. There is an improvement required around documenting all incidents. Dominion Home has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service programme that has been implemented for the 2013 year and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and caregivers report staffing levels are sufficient to meet resident needs.

Outcome 1.3: Continuum of Service Delivery
The service has a comprehensive information pack that is given to all inquiring families. Entry criteria and access process are clearly defined in policy and the resident information pack. The registered nurse carries out admission procedures. The registered nurse develops assessments and care plans. Cares and support are primarily

provided by caregivers under the supervision of the general manager/ registered nurse.

A range of assessment tools are completed in resident files on admission and completed at least six monthly. Risk assessment tools and monitoring forms are available and implemented including behavioural management plans for each resident. Resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Service delivery plans are individualised. Short term care plans are in use for changes in health status. The general practitioner and other health professional's document notes in the resident file and residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility. An improvement is required to updating the care plan as changes occur.

An activities coordinator works seven hours per day, four days per week. There is a programme planned for that includes games, TV, movies, arts and crafts, exercises, garden walks, entertainers and hand therapy. Activities are supported by caregivers outside of the activities coordinators hours. Family members interviewed report residents enjoy activities and all state that there is always something happening when they come into the service. An improvement is required to documentation of a 24-hour activity plan.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary.

Food services policies and procedures are appropriate to the service setting with nutritional snacks available on a 24-hour basis. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness The facility is maintained with contractors used when required. There is a refurbishment programme in place. There is a safe and secure external area for residents to access. The external and internal environment is arranged with a lot of space for walking and indoor/outdoor activities. Corridors are wide enough in all areas to allow residents to pass each other safely and there are safety rails appropriately located. Staff confirm that they have access to appropriate equipment, that equipment is checked before use and staff are competent to use the equipment. The facility provides evidence of safe storage of equipment with equipment calibrated annually.
Chemicals are safely stored with a trolley that is kept secure when in use. There is an improvement required around providing a secure environment.

Outcome 2: Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Resident files sampled have detailed plans around the management of behaviours that challenge. There are no residents using enablers. Staff received training around maintaining a restraint free environment, including the management of behaviours that challenge in January 2012.

Outcome 3: Infection Prevention and Control

The infection control nurse is the registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored

through the internal audit programme. There is an improvement required around training for the infection control coordinator. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to the quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. There have been no outbreaks since the previous audit.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	40	0	4	1	0	0
Criteria	0	88	0	4	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	5	0	0
Criteria	0	0	0	0	0	7	0	1

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	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.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	A review of one resident's file identified three incidents of absconding in November 2013 for which no incident forms were documented.	Ensure all incidents are reported through the incident/accident reporting system.	90
HDS(C)S.2008	Standard 1.3.7:	Where specified as part of the service delivery plan for a	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Planned Activities	consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.				
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	An individualised 24-hour activity plan is not documented. The activities coordinator states that the plans do not currently reflect a 24-hour programme.	Document an individualised 24-hour activity plan for each resident.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Two of five files do not document changes in care as these occur outside of the six monthly reviews. Examples include i) one resident who has lost 4.9kgs of weight since admission in November 2013 with the care plan not updated to reflect this (note that the registered nurse states that the general practitioner has been informed); ii) care plan not updated for one resident who has a change in behaviour around intimacy.	Update care plans in response to changes for an individual resident.	60
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.4.7.6	The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.	PA Low	One resident who is deemed not to be safe to leave the unit alone, according to the behaviour plan, was aware of the key code to exit the property and had done so on three occasions in November 2013. It is noted that a behaviour management plan was developed in November 2013 that included locking the resident's gym bag away and the resident had not absconded since this time. The key code was changed during the audit after the auditors highlighted the issue. Another resident is aware of how to access the kitchen even when the door is closed (there is no specific lock) and the resident was seen to do this twice during the audit. Her ability to do this was confirmed by staff. A more secure lock was placed on the kitchen during the audit following the issue being raised by the auditor.	Ensure a secure environment is provided for all residents at the facility.	90
HDS(IPC)S.2008	Standard 3.4: Education	The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	PA Low			
HDS(IPC)S.2008	Criterion 3.4.1	Infection control education is	PA Low	The IC coordinator has	Ensure the IC coordinator	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		provided by a suitably qualified person who maintains their knowledge of current practice.		not yet attended external specialist training. The general manager reports this is booked for later in 2014.	attends training appropriate to the role.	

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: There is a code of rights policy. On interview, all staff (two caregivers, one general manager, one registered nurse (RN) and one activities coordinator) was aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of rights is discussed at family and staff meetings. Five of five family members interviewed spoke very highly of the staff's respect of all aspects of the code of rights. Code of rights training including advocacy, informed consent and privacy was last carried out by the Health and Disability advocate in June 2013 and 18 staff attended.

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

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

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA
Evidence: There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service family / whanau / EPOA, receive an information pack that they can discuss with the general manager (GM) or registered nurse that includes a code of rights information and a service agreement. Large format and Maori information is also available for residents and family members. On interview all staff (two caregivers, one GM, one registered nurse (RN)), stated that they take time to explain the rights to residents and their family members. Five of five family members confirmed that they had received information about their rights on entry to the service. The service is able to provide information in different languages and/or in large print if requested. Information packs and discussions with family/whanau/EPOA and residents include the code of rights, complaints and advocacy. On interview, five of five family members were able to state their understanding of the code of rights. Health and disability advocacy service leaflets are on display on notice boards and in the facility. A brochure advertising the service is also included in the information pack provided to the family/whanau/EPOA of new residents. The service can access local Maori advisory services should this be requested. Education on advocacy services was provided in June 2013 as part of Code of Rights training and 18 staff attended. D6, 2 and D16.1b.iii: The information pack provided to family/whanau/EPOA on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission information.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. Five of five family members interviewed stated staff were highly respectful and maintained resident's privacy especially when discussing personal issues and those personal belongings are not used as communal property. Privacy training as part of code of rights training occurred in June 2013 and 18 staff attended. The resident's initial assessments and care plans comprehensively detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All five family members interviewed stated that resident's needs were met. Cultural awareness training occurred in May 2013 and 18 staff attended. All five resident files have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All family members interviewed could confirm this. There is a spiritually policy. Multidenominational services are conducted in the facility at least every two weeks. Local church groups and choirs are encouraged visit the facility. All family members interviewed indicated that resident's spiritual needs are being met. On interview, all family members interviewed stated staff respect residents rights. The service includes emotional wellbeing in the care planning process. Resident preferences are identified during the admission and care planning processes occur with full family involvement. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with all family members confirmed that resident's choices are considered. On interview, two caregivers described how they encouraged residents to engage in activities in the facility. There is a policy on abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training last occurred in November 2013 and 10 staff members attended. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Five of five family members were highly complementary of the care provided and stated staff were very approachable and friendly. One resident file sampled where the resident was one of two expressing intimacy contains a 'decision tree for assessing competency to participate in an intimate relationship'. Staff report carefully monitoring the resident and redirecting him when his is being close with the other resident. This information is not, however, included in the care plan (link 1.3.8.3).

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.
D14.4: There are clear instructions provided to family members on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.
E4.1a All five family members interviewed stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.
D4.1a Resident files reviewed identified that cultural, spiritual values and individual preferences are identified.

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

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

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

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

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

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)
Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)
Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)
Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA
Evidence:
The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan and recognition of Maori values and beliefs policy. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures.

Staff training includes cultural safety at orientation. In service training occurs two yearly. There is presently one resident who identifies as Maori and her cultural needs are included in her care plan. Dominion Home identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.
Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the registered nurse with the inclusion of the family / whānau / EPOA. The service identifies opportunities to involve family/whānau in all aspects of planning individual's service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with the registered nurse and two caregivers confirm that they are aware of the need to respond to cultural differences. On interview, all staff were able to identify how to obtain support so that they could respond appropriately.

A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).
D20.1i: The service has developed a link with DHB Maori advisory and advocacy service, Oranga Hinengaro.

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All family members interviewed reported that they were satisfied that residents cultural and values were being met.
Family are involved in assessment and the care planning process. Information gathered during assessment including resident's cultural, beliefs and values is used to develop a care plan, which the family/whānau/EPOA is asked to consult on. All parties involved in the consultation process reach agreement and the care plan is implementation within the service delivery.
Two residents identify as Hindu (one is on respite care). Both have different dietary requirements and each of these individual requirements is catered to. Both can speak and understand English.

D3.1g: The service provides a culturally appropriate service by applying their cultural policies and assessing resident's cultural needs with their family/whānau/EPOA and embedding these needs in residents, care plans.
D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)
The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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: The facility has a sexuality policy which states there will be zero tolerance against any discrimination occurring. The abuse and neglect policy covers harassment and exploitation. All family members interviewed reported that the staff respected residents. Elderly abuse prevention training occurs at orientation and on a two yearly basis and includes professionalism and standards of conduct. Training last occurred in November 2013 and 16 staff members attended. The registered nurse supervises staff to ensure professional practice is maintained in the service. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

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: The service has policies to guide practice that align with the health and disability services standards. A quality framework that is being implemented supports an internal audit programme. The caregivers are required to complete ACE NZQA dementia level training and an internal in-service training programme is implemented. Both the GM and registered nurse attend external training sessions appropriate for their positions. A2.2: Services are provided at Dominion Home that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. D1.3: All approved service standards are adhered to. D17.7c: There are implemented competencies for caregivers and the registered nurse. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is policy on disclosure of health information, which describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to family/whānau/EPOA on entry to the service. The pack includes a copy of the code of rights. This information is discussed at entry and staff are available whenever family/whānau/EPOA wish to discuss any aspect of service delivery. Family are involved in the initial care planning, receive, and provide on-going feedback.
Regular contact is maintained with family including if an incident or care/ health issues arises. Five of five family members interviewed stated they were well informed and involved when needed in residents care. All family members interviewed confirmed the admission process and agreements documentation were discussed with them. Family state the service provides an environment that encourages open communication.
There is a Facebook page, which is well advertised to families and contains regularly updated information about happenings in the home, activities, staff etc. No resident names are used on the Facebook page and families have consented to resident photos being put on the Facebook page.
The owners attend the service regularly and families interviewed report they are easily available. They also attended the Christmas function and families report positive interaction at this event. Families interviewed spoke very highly of how available the registered nurse and manager are to discuss any concerns. All family members are provided with an individual monthly email to update them on their resident's progress and condition.
The admission agreement covers all the areas for the services contractual requirements. All five resident files reviewed included signed admission agreements on the date of admission.
Discussions with two caregivers identified their knowledge around open disclosure and reporting to the facility manager who in turn contacts family. Eleven incident/accident forms were reviewed, and all had a corresponding email that identified that the next of kin were contacted. There are three monthly relatives meetings where any issues or concerns are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised. Annual relative surveys are also completed and entered into the QPS benchmarking system, which benchmarks services throughout Australasia. Family members in the 2013 survey are very satisfied with the service. Privacy and sufficient time for discussion with family members can be obtained in resident's rooms, the lounge area or dining area if needed. All staff wear name badges.
The service has policies and procedures available for access to DHB interpreter services and family/whānau/EPOA are provided with this information in resident information packs.

D12.1 Non-Subsidised family members of residents are advised in writing of resident's eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to family on entry to the service.
D16.1b.ii Family/whānau/EPOA and residents are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b Five of five family members stated that they are always informed when their family members health status changes.
D11.3 The information pack is available in large print and advised that this can be read to family members and residents.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)
Consumers have a right to full and frank information and open disclosure from service providers.

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

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)
Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)
Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

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

Attainment and Risk: FA
Evidence: Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with two caregivers identify that consents are sought in the delivery of personal cares.

Written consent includes the signed admission agreements and consent for transporting, photographs and provision of care. One resident has not ever had family or an enduring power of attorney involved but has recently had one appointed. The appointee had the agreement sent in December 2013 and the service is waiting for the response. Another resident has family involved who refuse to sign the agreement. This is documented on the agreement.
All five resident files reviewed have signed consent forms signed by the family/whanau/ EPOA.
Advanced directives / resuscitation policy is implemented in all five resident files reviewed. All advance directives are completed by the GP who has documented that each resident is incompetent to make an advance directive.
D13.1 There are five admission agreements sighted and all had been signed on the day of admission
D3.1.d Discussion with five family identifies that the service actively involves them in decisions that affect their relatives lives and all state that they are kept well informed.

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.

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 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)
Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

Attainment and Risk: FA
Evidence: There is an advocacy policy. Staff last received training on advocacy services as part of code of rights training in May 2013 and 18 staff attended. Information about accessing advocacy services is available at the nurses' station and on notice boards. The information pack provided to family members and residents at the time of entry to the service provides advocacy information. Advocate support is available if requested. Interview with two caregivers and five family members informed they are aware of advocacy processes and how to access an advocate. D4.1d; Discussion with five family identified that the service provides opportunities for the family/whanau/EPOA and resident to be involved in decisions. D4.1e: The resident file includes information on resident's family/whānau and chosen social networks.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)
Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: Community groups including church and support groups are encouraged to be involved with the facility. Residents are encouraged to maintain family and friends networks. On interview all staff (two caregivers, one activities coordinator and the registered nurse), stated that residents are encouraged to build and maintain relationships. On interview, family members confirmed this. One resident attends the local gym six days per week with an escort. D3.1h: Discussion With five families that they are encouraged to be involved with the service and care D3.1.e: Discussion with two care staff and five relatives confirms that residents are supported and encouraged to remain involved with the community and external groups such as church group visits.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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 service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with five family members inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints There is a complaints register. The 2012 and 2013 complaints were reviewed (one for each year). Verbal and written complaints are documented. Both complaints were regarding residents with challenging behaviour. The complaints have noted investigation, time lines, corrective actions and resolutions noted. Results were feedback to the complainants. Discussions with five family members confirmed that any issues are addressed and they feel very comfortable bringing up any concerns. Discussions with two caregivers stated that concerns/complaints were discussed at monthly staff meetings, three monthly integrated quality assurance committee meetings and six monthly management review meetings. The general manager reports there have been no complaints or investigations involving the Ministry of Health, District Health Board, Health and Disability Commission or any other external agency. D13.3h: A complaints procedure is provided to family members and residents within the information pack at entry E4.1biii: There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on: 1. Minimising restraint. 2. Behaviour management.

3. Complaint policy.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Dominion Home provides rest home secure dementia services for up to 29 residents. There are currently 24 residents including one resident on short term respite care. The facility changed ownership in March 2013 and the previous owner/manager has stayed on as the general manager. Dominion Home's mission statement is "to provide residents with quality care appropriate to their individual needs and wishes, taking into account any cultural and religious preferences". The philosophy which is included in the pre-entry information booklet that is included in the information pack talks about the quality of life for each resident and enabling their involvement and their family/whanau/EPOA in making decisions that affect their lives. The general manager has developed a 2013 -2014 business plan that includes goals, vision, purpose and values. There are five goals for 2014 identified and these are around maintaining a high standard of quality care, completion of dementia papers for staff, building improvements, continuing reading research and expanding the Facebook page. The executive summary for 2013 includes that the goals for that year were met including garden improvements, completing the transition following the change of ownership and encouraging family surveys. Service goals are reviewed at six monthly management meetings. Quality improvement and risk management and the mechanism for monitoring progress are outlined. Progress towards goals is managed through audits, monthly staff meetings and reported through to the three monthly integrated quality assurance committee meeting and six monthly management review meeting. There is an internal audit schedule that aligns with the business plan and is implemented and a corrective action plan used to manage shortfalls. There is a two yearly schedule for reviewing policies and this is implemented.

The service is managed by the general manager (GM), who previously owned and managed the facility for four years. She has had previous experience in management in the rest home secure dementia service sector. She has 33 years' experience in the aged care sector including in management roles. She is supported by an experienced registered nurse who has worked in the facility for over 18 months as a caregiver and has been in the current role since completing his competency assessment and gaining New Zealand registration in May 2013. The GM and registered nurse share on-call. Job descriptions for the GM and the registered nurse outline their authority, accountability and responsibility. D17.3di: Both the GM and the registered nurse have completed on-going training appropriate to their positions. The general manager attended the New Zealand Aged Care Association conference in 2013.

E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: In the absence of the GM, the registered nurse oversees the management of Dominion Home. The service has policies to guide practice and are appropriate for dementia service level care. Dominion Home is certified to provide 29 rest home secure dementia service level beds. At the time of audit, there are 24 residents. Family/whanau input is sought through three monthly family meetings and annual satisfaction surveys. D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)
During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)
The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

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

Attainment and Risk: FA
Evidence: Dominion Home has a quality programme that is being implemented. The GM is directly involved in operations at the facility. There is a 2013-2014 business plan that includes objectives/goals for the year and a quality assurance plan, which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (two caregivers, activities coordinator, GM and registered nurse); inform an understanding of the quality activities undertaken at Dominion Home. Family meetings occur three monthly (minutes viewed). Five of five family members interviewed are aware meetings are held. Annual surveys are conducted of family/whanau. All family members interviewed stated they are regularly asked for feedback regarding the service. At the time of audit family/whanau feedback indicated satisfaction with the service. D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans. D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g: Falls prevention strategies such as analysis of fall data, individual assessments and ensuring walkways are uncluttered. Policies and procedures are in place with evidence of two yearly reviews. The GM, business manager and registered nurse manage quality systems. The quality programme is reviewed yearly and is being implemented. Information is reported through the monthly staff meetings, three monthly integrated quality assurance committee and six monthly management review meetings. All meetings discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. Information is then reported back to all meetings. Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility. Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Dominion Home is restraint/enabler free at the time of audit. There is a 2013 and 2014 internal audit programmes include (but are not limited to); activities, disturbing behaviour management, food, emergency, cleaning and

medication. All issues found in the 2013 audits have identified corrective action plans and resolutions. Results of audits are discussed in quality and staff meetings.
Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to quality and staff meetings. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been regularly completed and documented in the quality/staff meeting minutes. All staff interviewed could describe the corrective action process.
The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.
Dominion Home has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be well utilised. Two caregivers interviewed are aware of hazard reporting.
The service is seen to be proactive in minimising/eliminating environmental hazards/risk.
The service uses QPS benchmarking to enable their quality systems to be measured against facilities throughout Australasia. The benchmarking tool has specific dementia specific data indicators and measurements and appropriate benchmarking occurs against similar facilities. All results analysis is reported to staff meetings and corrective actions are generated when required if trending indicates issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)
Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

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

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)
A process to measure achievement against the quality and risk management plan is implemented.

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

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)
A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the general manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and then onto quality meetings. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential

notification.
Incidents/accidents for September 2013 to November 2013 (there were no reported incidents in December 2013) were viewed and 11 forms were viewed from this time. There is evidence in all forms viewed of appropriate investigation, corrective action planning, implementation of plans and follow-up when required. However, a review of one resident's file identified three incidents of absconding in November 2013 for which no incident forms were documented. This is an area requiring improvement.

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the facility manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and then onto quality meetings. Incidents/accidents for September 2013 to November 2013 (there were no reported incidents in December 2013) were viewed and 11 forms were viewed from this time. There is evidence in all forms viewed of appropriate investigation, corrective action planning, implementation of plans and follow-up when required.
Finding: A review of one resident's file identified three incidents of absconding in November 2013 for which no incident forms were documented.

Corrective Action: Ensure all incidents are reported through the incident/accident reporting system.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of the registered nurse is current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on the five staff files sampled (the registered nurse, the activities coordinator, the cook and two caregivers) including signed contracts, job descriptions, orientation and training. There is an annual appraisal process in place and appraisals are current in all files reviewed. The initial sample of five files did not include reference checks as all these staff had been employed through knowing the general manager, having worked with her previously, or have been known to other senior staff. The sample was extended by four staff files, specifically around reference checks and all had a documented reference check. A training/induction process describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interview with two caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision could be extended if needed. The registered nurse verified this. The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance recorded at sessions kept. Interview with two caregivers inform there is access to sufficient training. Medication competencies are completed for the registered nurse and caregivers who administer medication. D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication E4.5d: The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies. E4.5f: There are eleven caregivers. Six have completed the required dementia standards and the other five caregivers are in the process of completing and have not yet been at the service for one year.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA
Evidence: The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the GM or the registered nurse will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The registered nurse works full time and is on call.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

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

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA
Evidence: Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident and family/whānau All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident's files include allied health professional, specialist, GP input, and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. All activities progress notes for all residents are written on the same page in the activities file. The service should consider integrating these with other notes. Information in files is appropriate to the rest home secure dementia services setting. The service keeps a resident register. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses' station in a secured room. Old files are individually archived and locked in a secure area for 10 years. Resident records are up to date, reflect residents' current overall health, and care status. Only relevant personnel can access records. Care plans and progress notes are legible, signed and dated by the registered nurse and caregivers. Medical notes and allied health input are signed and dated appropriately. D7.1: Entries are legible, dates and signed by the relevant caregiver or facility manager/RN including designation.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

Attainment and Risk: FA	
Evidence:	
Finding:	
Corrective Action:	
Timeframe (days):	*(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: 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 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)
Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

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

Attainment and Risk: FA
Evidence: The service has a comprehensive information pack that is given to all inquiring families. Entry criteria and access process are clearly defined in policy and the resident information pack. Interviews with five of five family members indicate that entry criteria and access processes were made clear to them. Five of five resident files sampled have a signed admission agreement. E4.1.b There is written information on the service philosophy and practices particular to the unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on: 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement

E3.1 Five resident files were reviewed and all include a needs assessment as requiring specialist dementia care.

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

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

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

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

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

ARHSS D4.2

Attainment and Risk: FA
Evidence:
The service has policies around declining entry and processes to be followed when an entry is declined including communicating with the referrer and the potential resident and/or their family. The service has declined entry to one potential resident as reported by the general manager and facility manager/ registered nurse. There is documented evidence that the referrer was informed of this by fax. The service states that the needs assessor was responsible for informing them of other suitable options.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Admission procedures are carried out by the facility manager/ registered nurse. The registered nurse develops assessments and care plans. Cares and support are primarily provided by caregivers under the supervision of the facility manager/ registered nurse (current practicing certificates sighted). There is a registered nurse on duty or on call at all times. A range of assessment tools are completed in resident files on admission and completed at least six monthly including (but not limited to); falls, pressure area risk, dietary requirements and continence for five of the five files sampled. Pain is assessed on an as needed basis and weights are monitored monthly – sighted for five of five residents reviewed. There is evidence in all five files of continuity of service delivery including progress notes written every one to three days. The general practitioner and other health professionals including the podiatrist and the mental health service for older people document notes in the resident file. Two caregivers interviewed report a thorough handover and use of the communication book to ensure service delivery continuity. D16.2, 3, and 4: The five files reviewed identified that in four of five files an initial assessment and initial care plan was completed within 24 hours and in four of five files, the long term care plan is completed within three weeks. The fifth file that did not have an initial assessment and care plan completed in a timely manner was for a resident who entered the service in 2009. The sample of resident files was increased by two recent admissions and all have an initial assessment and care plan documented on the day of entry. There is documented evidence that the care plan i.e. reviewed by a registered nurse. Five of the five care plans evidences evaluations completed at least six monthly.

D16.5e: Five of five resident files reviewed identifies that the general practitioner has seen the resident within two working days of admission with at least three monthly (and as needed) reviews in three of five files sampled. The general practitioner documents frequency of reviews.
The reviews of the care plans indicate that all plans have family input.

Tracer Methodology:

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

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

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

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

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

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

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

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)
The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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

Standard 1.3.4: 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: The nursing assessments completed on admission are comprehensive. Care plans are an individualised document that includes support needs, problem/goal, interventions and evaluation. In five of five residents files sampled relevant needs and required interventions have a section in the plan that are well completed and individualised and reflect needs identified in the assessments. Two caregivers interviewed report care plans are easy to follow. Five of five residents files sampled include input from the doctor, podiatrists, mental health services and staff from the facility. E4.3 Five resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. D16.3f: Five of five resident files reviewed identified that family are involved in the assessment process.

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: Assessments completed on admission are comprehensive. Care plans are an individualised document that includes support needs, problem/goal, interventions and evaluation. In five of five residents files sampled relevant needs and required interventions have a section in the plan that are well completed and individualised and reflect needs identified in the assessments. Two caregivers interviewed report care plans are easy to follow. Five of five residents files sampled include input from GP's podiatrists, physiotherapists, mental health services and all staff from the facility. E4.3 Five resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. D16.3f: Five of five resident files reviewed identified that family were involved. Behavioural plans are in place in all files reviewed.

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: Five resident care plans reviewed include one resident with challenging behaviour, one resident with unintended weight loss, one new admission and two others also with dementia requiring a secure unit. The care being provided is consistent with the needs of residents with this evidenced by discussions with the two caregivers, registered nurse, five families and the general manager. The general practitioner interviewed praised the care provided at Dominion Home. Five of five interviewed reported that they were warmly welcomed to the service, shown around and introduced to staff and consumers. The registered nurse completes residents care plans. Care delivery is recorded with progress notes documented every one to three days and as changes occurs. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. One resident had a change in behaviour in the past two months and the resident has been referred to mental health services for older adults and the general practitioner is assessing the need for a change in medication. General practitioner documentation is kept in the resident's file. Interviews with two caregivers and the facility manager/ registered nurse indicate that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. Five of five family members interviewed are complimentary of care received at the facility. The care witnessed to be provided on the day of the audit meets the needs of residents and at all times is seen to be respectful. There are no residents with wounds currently.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. The staff try to use pull-ups particularly during the day as they state that these are more comfortable for residents and more respectful. Specialist continence advice is available as needed and this can be described. Continence management in-services and wound management in-service have been provided.

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: An activities coordinator works seven hours per day, four days per week. She is mentored by an occupational therapist who visits one to two weekly. There is a programme planned for that includes (but is not limited to): games, TV, movies, arts and crafts, exercises, garden walks, entertainers and hand therapy. Residents are also able to fold washing or set tables if they wish. One to one activities are provided for those not able to or interested in joining in the group programme. The service has regular outings three times per week. Activities are supported by caregivers outside of the activities coordinators hours. Entertainers visit on weekends and Wednesdays and there is a fortnightly communion service. Five of five family members interviewed report residents enjoying activities and being able to make requests of the activities included in the programme. All state that there is always something happening when they come into the service. Resident activity files are kept in a separate folder by the activities coordinator who states that staff have access to the folder (link 1.2.9.10). D16.5d Each resident has an activities assessment with history documented, activities identified in a plan that the resident likes doing and evidence of six monthly reviews. An attendance register is kept for each resident.

An improvement is required to documentation of a 24-hour activity plan.

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

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

Attainment and Risk: PA Low
Evidence: Each resident has a documented assessment and plan with evidence of six monthly reviews. A monthly activity programme is documented.
Finding: An individualised 24-hour activity plan is not documented. The activities coordinator states that the plans do not currently reflect a 24-hour programme.
Corrective Action: Document an individualised 24-hour activity plan for each resident.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Low
Evidence: Five of five client files reviewed contain documented evaluations against each area of the care plan at least six monthly. Four D16.3k: Short term care plans are in use for changes in health status or the long term care plan is updated. Interview with five of five family members indicate that care is reviewed with them. D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. D16.3c: All initial care plans are evaluated by the RN within three weeks of admission. An improvement is required to review of care plans as changes occur.

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Three of five files reviewed show that care plans are updated as changes occur.
Finding: Two of five files do not document changes in care as these occur outside of the six monthly reviews. Examples include i) one resident who has lost 4.9kgs of weight since admission in November 2013 with the care plan not updated to reflect this (note that the registered nurse states that the general practitioner has been informed); ii) care plan not updated for one resident who has a change in behaviour around intimacy.
Corrective Action: Update care plans in response to changes for an individual resident.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: There is a policy around referral to other health and disability services. Five of five family members interviewed are aware of their options to access other health and disability services and are provided with information and supported through this process. All confirm advice has been provided by the facility. The registered nurse interviewed report that possible options to which a resident might be referred include (but are not limited to): NASC; hospital geriatricians and rehabilitation services; speech language therapists; dieticians, Medlab; radiological services; hospital specialists; cultural organisations or social workers. Advocacy information is available in the facility. When a resident requires a referral to another service, the general practitioner takes responsibility for this task. An explanation is given to the resident and their family/whanau who is kept informed as appropriate. Documentation relating to referrals and completed referral forms were sighted in resident files sampled. Progress notes demonstrate staff contact family when referrals for specialist review or transfer is necessary. Family members interviewed were satisfied that they were kept well informed about referrals and/or transfer to hospital where this had occurred. D16.4c; The service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with the facility manager/ registered nurse identifies that the service has access to NASC; hospital geriatricians and rehabilitation services; speech language therapists; dieticians, Medlab; radiological services; hospital specialists; cultural organisations or social workers.

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

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

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: The service has policies for transfer or exit of the service, which describes guidelines for death, discharge, transfer, documentation and follow up. All relevant information is documented and communicated to the receiving health provider or service. D 21.1: A transfer form accompanies residents to receiving facilities with a transfer letter from the facility photocopied with accompanying relevant documentation including medication charts. D21.3: When a resident wishes to leave the facility, the NASC service is notified as reported by the registered nurse. All relevant information is documented and communicated to the receiving health provider or service, notes are photocopied. Five of five family members interviewed were satisfied that they were kept well informed about referrals and/or transfer to hospital where this had occurred. Staff could describe the referral and or transfer processes and demonstrated an understanding of the resident right to be informed.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Ten medication charts were sampled and all medication was looked at in the locked cupboard, the medication fridge and the trolley. The facility uses the medication management system of blister packs with these delivered in a two week supply. Medication is checked on delivery and stored safely and all medication charts are legible and reviewed three monthly. Controlled drugs are stored in a locked cupboard and weekly stock takes occur (no controlled drugs currently in the service). The medication fridge temperature is monitored daily and is within safe ranges. There are appropriate medication policies and procedures including around residents who self-administer medicines with no residents self-administering medication on the day of the audit. The caregivers administer medicines. There has been training around medication administration in March and July 2013 and this is discussed at staff meetings as sighted in meeting minutes following a medication audit. All staff who administer medication have current competency assessments. All eye drops sighted have been dated when they were opened. Ten of ten medication charts sampled have photo identification and document allergies. Ten of ten medication administration signing sheets have all medication signed as having been administered. D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart is signed.

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

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

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

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)
Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)
The facilitation of safe self-administration of medicines by consumers where appropriate.

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)
Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: Food services policies and procedures are appropriate to the service setting with the menu having been reviewed by a dietician 3 December 2013. There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietitian and speech language therapist as required. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Copies of dietary profiles reviewed in the kitchen and in resident files and likes and dislikes are catered for. Special equipment is available as needed. Residents are offered fluids throughout the day and were observed to take drinks that are left out. D19.2 Staff have had training around dehydration and fluids last in February 2013. Resident files sampled demonstrate regular monthly monitoring of individual consumer's weight and nutritional needs, and nutritional needs and interventions are identified and documented. Family members interviewed are very complimentary of the food service provided and report that resident's individual preferences are well catered. Visual inspection of the kitchen provides evidence of compliance with current legislation and guidelines. The weekday and weekend cooks have completed food safety education and evidence of this was reviewed on their files. Monitoring records available include food temperatures and fridge / freezer temperature recordings for the kitchens and are within recommended ranges. E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours.

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

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets available throughout the facilities and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances with chemical training provided in July 2013. A visual inspection of the facility evidences the provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening that is secure on the cleaning trolley. The cleaner interviewed confirms knowledge of keeping the cleaning trolley secure while cleaning.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Service providers' documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and are reviewed. The site is secure (link 1.4.7.6). Medical equipment was calibrated in February 2013. Hot water temperatures are monitored monthly and are with a range of 43-45 degrees Celsius. Service provider's documentation and visual inspection evidences a current Building Warrant of Fitness that expires on 29 September 2014. A visual inspection of the facility provides evidence of safe storage of equipment. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located; minimal changes in floor surface and levels occur; equipment does not clutter passageways etc; transitions between surfaces or coverings are without abrupt change in level or gradient; and floor surface changes are identifiable by the resident. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade. The facility manager/ registered nurse and two of two caregivers interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment. Family interviewed confirm they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Family interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs. D15.3: The following equipment is available: shower chairs and lifting aids. E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities. E3.3e: There are quiet, low stimulus areas that provide privacy when required. E3.4.c: There is a safe and secure outside area that is easy to access.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)
All buildings, plant, and equipment comply with legislation.

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)
The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)
Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: Visual inspection evidences toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. The requirements of the New Zealand Building Code are met. All bedrooms are single, except two, one of which is shared by two residents and the other is saved for respite residents. There are adequate numbers of toilets and showers to cater to all residents. The toilets have appropriate access for residents based on their needs and abilities and facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. This observation was confirmed during interviews of staff and family.

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: Visual inspection shows that there is adequate access is provided to lounge, dining and other communal areas and that residents are able to move freely within these areas. Five of five family interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and the resident does not want to participate in them. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander noting that there is a locked half gate in the kitchen to deter residents from accessing the kitchen and two locked gates that prevent residents from wandering outside the property (refer 1.4.7).

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: Cleaning policy and procedures, and laundry policy and procedures are available. Product user charts and chemical safety data sheets for all chemicals used in the facility was sighted. There are policies and procedures for the safe storage and use of chemicals / poisons. Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. The chemicals provider conducts cleaning audits monthly and a laundry audit (with 100% compliance) was last completed in November 2013. Visual inspection of the facilities evidences: safe and secure storage areas are available and service providers have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas. Staff files reviewed indicate attendance at chemical safety education in July 2013 and staff interviews confirm education on chemical safety and management of waste and hazardous substances has occurred. Family interviewed state their satisfaction with the cleaning and laundry services.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)
The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)
Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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: PA Low
Evidence:
Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also

policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors. There is improvement required around providing a secure environment.
Letters from New Zealand Fire Service reviewed dated 18 September 2008 advising approval of fire evacuation schemes. The last trial evacuation was held on 12 November 2013.
Staff interviews and review of files provides evidence of current training in relevant areas. All staff (except the newest who are never on duty alone) have current first aid certificates as confirmed in staff interviews and in staff files sampled. Emergency and security situation education is provided to service providers during their orientation phase and at appropriate intervals. This includes fire safety training and emergency security situations. Staff records sampled evidences current training regarding fire, emergency and security education. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the service agreement.

A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is also emergency lighting, torches, extra food supplies, emergency water supply, blankets, and cell phones. There is a gas barbeque should the mains gas supply fail. An appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, ablution areas, ensuite toilet/showers, the lounge and dining room.
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

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

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)
Where required by legislation there is an approved evacuation plan.

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

Attainment and Risk: PA Low
Evidence: Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.
Finding: One resident who is deemed not to be safe to leave the unit alone, according to the behaviour plan, was aware of the key code to exit the property. The key code was changed during the audit after the auditors highlighted the issue. Another resident is aware of how to access the kitchen even when the door is closed (there is no specific lock) and the resident was seen to do this twice during the audit. Her ability to do this was confirmed by staff. A more secure lock was placed on the kitchen during the audit following the issue being raised by the auditor.
Corrective Action: Ensure a secure environment is provided for all residents at the facility.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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: There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. Family interviewed confirm the facilities are maintained at an appropriate temperature.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: There is a restraint policy, which states the home actively promotes a policy of least restraint and is currently a restraint free environment. The policies include comprehensive restraint procedures should these be required. A comprehensive checklist for safe and appropriate use of restraints is used that includes, but is not limited to, management strategies to avoid restraint use, behaviours that indicate the need for restraint, type of restraint to be used, monitoring requirements when restraint is used and evaluation of restraint use. There is a definition of enablers that states 'equipment, devices or furniture, voluntary used by a resident following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and / or safety. The use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining resident's independence and safety'. There are no resident's using restraint or enablers at the time of the audit. Staff had training on restraint including de-escalation in January 2012. Dominion Home meets the requirements of 8134.2.2 and 8134.2.3. Policies and procedures are comprehensive to guide staff in the event that restraint should be needed. E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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

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

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

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

Standard 3.1: 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 registered nurse has been the infection control (IC) coordinator since his employment in the role in May 2013 and he can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC coordinator. IC is a standing agenda item at the monthly staff, three month quality and six monthly management review meetings(minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC Coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register. There is a job description for the IC coordinator including the role and responsibilities. IC is part of the audit schedule and was last undertaken in August 2013. 100% compliance was achieved. There are policies and an infection control manual to guide staff to prevent the spread of infection.

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

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

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)
The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)
Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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

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 registered nurse is the infection control coordinator and IC matters are taken to the monthly staff and three monthly quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. He is responsible for

reviewing the IC programme annually. The RN complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete annual infection control education last conducted in June 2013 and 12 staff members attended. Access to specialists from the DHB, laboratories and GPs is available for additional training support. The RN has access to all relevant resident information to undertake surveillance, audits and investigations.

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: Dominion Home has infection control policies and an infection control manual, which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator (RN). The IC coordinator reviews the IC programme annually and she can access external specialist advice to do this. D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.

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: PA Low
Evidence: The IC coordinator is the registered nurse who has been in the role since May 2013. He has not yet attended external specialist training and this is an area requiring improvement. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education was delivered in June 2013 and 12 staff attended. The training folder records the staff education and attendance. External resources can include DHB, labs and GP's input to ensure the content of the education sessions are current and reflect best practice. Family/whanau and resident education occurs as part of care delivery. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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: PA Low
Evidence: The IC coordinator is the registered nurse who has been in the role since May 2013.
Finding: The IC coordinator has not yet attended external specialist training. The general manager reports this is booked for later in 2014.

Corrective Action: Ensure the IC coordinator attends training appropriate to the role.
Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

Attainment and Risk: FA
Evidence: Infection monitoring is the responsibility of the infection control coordinator who is the registered nurse. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff and three monthly quality meetings that include a cross section of staff (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility Internal audit of infection control is included in the annual programme and was last conducted in August 2013. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

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

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

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